

TESTING THE BOP IMPACT ASSESSMENT FRAMEWORK
THROUGH ASSESSING SOCIO-ECONOMIC IMPACT
OF A HEALTH CARE VENTURE IN AFGHANISTAN

by

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A Thesis Submitted in Partial Requirement of the Doctorate of Business Administration
to Edinburgh Business School, Heriot-Watt University

September 2014

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ABSTRACT

This thesis explores impact assessment of a health care venture targeting the base of the pyramid market in Afghanistan. Little research has been conducted on BoP ventures in Afghanistan, and impact assessment represents a gap in the BoP literature. Therefore, to address the assessment gap in the BoP literature, the BoP Impact Assessment Framework was used as a theoretical template for designing the research study as well as generalising results. The study design included empirical, field research in rural Afghanistan, which provided a unique context for testing the existing framework. The case study method was used to conduct research on a single organisation providing health services in Afghanistan, and data was collected from multiple sources of evidence such as archival evidence, interviews and focus groups to triangulate results.

The research study incorporated grounded theory procedures and processes to collect, analyse and code raw data. Theoretical sampling, a central grounded theory procedure, facilitated theory development through the discovery and comparison of concepts and categories. Results were developed by theorising about the raw data compiled during data collection and analysed using grounded theory. The final empirical results included three broad categories – “lower health care costs”, “relationships” and “behaviours” – and represent the inductive theory that emerged from the research study. The inductive theory was subsequently generalised against the existing theoretical framework through analytical generalisation. In each case where the inductive theory was compared against the existing theoretical framework, the research study found that the empirical results were generalisable against the existing theory.

ACKNOWLEDGEMENTS

One of my favourite proverbs reads, *Trust in the Lord with all your heart and do not rely on your own understanding. In all your ways acknowledge Him, and He will make your paths straight.* This proverb was a guiding light during the entire research process, especially while conducting field research in rural Afghanistan.

I owe the deepest gratitude to the two closest people in my life – my wife and our daughter – as they have patiently supported me in more ways than I understand while I have poured countless hours into research. My wife has been my biggest supporter in all areas of life and my greatest cheerleader. She has helped me keep my sanity, and our daughter has brought immeasurable joy throughout the process.

I owe many thanks to my mentor Dr. Neil Kay who helped me initially get the research idea off the ground and my supervisor Dr. John Temperley for his excellent guidance, advice and support over the course of the entire research study.

I also owe much gratitude to several past and present ORU colleagues including Dr. Mark Lewandowski, Dr. Steve Greene, Dr. Marshal Wright and Dr. David Dyson for their advice and encouragement to initially pursue doctoral studies and for their support during the long research process.

I would like to acknowledge the WDI team for their industry leading work regarding the BoP field, particularly regarding impact assessment. I owe many thanks to Ted London, Heather Esper and Sateen Sheth personally and professionally for the initial development and conceptualisation of the research study.

Finally, I must express my sincere appreciation for the entire Morning Star Development staff for their many contributions to the research study. In particular, this study would not have been possible without Dan Batchelder, Dilip Joseph, Dr. Basir and Jalal Ghafoori.

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GLOSSARY OF TERMS

Balanced Innovation – Balance between knowledge of the business model and knowledge of the consumer

Base (or Bottom) of the Pyramid – General term used to denote a field of literature incorporating business strategy and poverty alleviation

BoP – Acronym for base of the pyramid or bottom of the pyramid

BoP Approach – An approach to global business strategy, in which new capabilities are required to penetrate BoP markets

BoP Demographic – A socioeconomic demographic of approximately four billion people that live on less than \$3,000 PPP per capita that typically conduct business in the extralegal or informal economy

BoP Market – A virtually untapped global market consisting of approximately four billion consumers and producers that have traditionally been excluded from global capitalism

BoP Perspective – A unique perspective on poverty alleviation, which requires the simultaneous pursuit of profits and poverty alleviation

BoP Protocol – comprehensive methodology that helps ensure BoP actors coevolve a new venture and a new market simultaneously through an embedded innovation process

BoP Venture – Term generally referred to in the BoP literature to describe organisational efforts targeting the BoP market

Business Model Development (also Business Model R&D) - The imperative for firms to fundamentally rethink and innovate their business models

Co-Creation – Process in which organisations collaborate with local partners in BoP markets that contribute information and input into everything from product design to pricing to distribution, which ultimately allows the product and business model to coevolve

Disruptive Innovation – a process by which a product or service takes root initially in simple applications at the bottom of a market and then relentlessly moves up market, eventually displacing established competitors

Inclusive Capitalism – Targeting business strategy at the BoP market to simultaneously earn profits and help the poor

Innovation Gap – divergence between increased knowledge of the business model and decreased knowledge of the consumer

Khahar-Khanda – Term of endearment used between women in Afghanistan that means God sister

Khob Shodan – Dari word respondents used to represent the warming of relationships. This is the same word used in Dari for the type of warming that is related to temperature so it is a word that can describe both the temperature as well as represent an expression of affection or kindness.

Local Embeddedness – When a company becomes part of the local landscape in a BoP market, rather than an alien force that imposes its will from the outside

Maharam – Term representing the common cultural requirement for women to be accompanied by a male escort (e.g. husband, father or brother) in order to leave their home residence

Mutual Value Creation – Dual focus on business strategy and poverty alleviation

Naan – Afghan bread

Native Capability – Capability that is central to the BoP approach to global strategy, which enables an organisation to build a web of trusted connections with a wide range of local market participants and become embedded within the local BoP market context

Nazrana – Term that represents a cultural practise in Afghanistan of giving gifts, which often equate to small bribes or informal payments in professional settings

Patient Capital – Capital that allows for a longer time horizon regarding financial returns

Patient Innovation – The combination of business model development and the investment of patient capital

Reshwat – Standard Dari word for bribe

Right at the BoP – Logic within the BoP perspective that recognises there is an inherent economic rationale to the extralegal economy, and as a result, indicates that BoP ventures enhance what already exists in the BoP market (e.g. resources, expertise and social infrastructure) and build from the bottom-up

Shereny – Slang word most Afghans use for bribe, which also means something that tastes sweet like candies or dessert

Shura – General term used in Afghanistan for council or committee

Strategic Design – A customer-centred and bottom-up approach to designing products and services for the BoP market

CHAPTER: 1 INTRODUCTION

The motivation for the research study relates to an emerging field of literature referred to as the base of the pyramid (BoP) as well as a desire to explore how business strategies might impact poverty alleviation in the health care sector in Afghanistan. As a result, it is necessary to combine two fields of literature, which includes the base of the pyramid and health care in Afghanistan. While the field of literature regarding the base of the pyramid has grown in breadth and depth, literature concerning health care in Afghanistan is fragmented and sparse. Although the primary thrust of the literature review is focused on the base of the pyramid, it is necessary to explore health care in Afghanistan to strengthen the overall review.

Thus, addressing the gap in assessment in the BoP literature requires the integration of literature concerning health care in Afghanistan in order to establish essential context for the study. Further, the current research study focuses on the critical area of impact assessment because there is little evidenced in the literature regarding how BoP ventures are actually helping the poor, yet the BoP concept rests upon the mutual value proposition of simultaneously earning profits and helping the poor. While there are many case studies on organisations launching profitable BoP ventures, there is virtually no empirical assessment in the literature regarding whether these ventures are actually benefitting the poor (London, 2009b).

Because assessment is virtually nonexistent in the BoP literature, the research question, aim and objectives are developed around an emergent assessment tool – the BoP Impact Assessment Framework. Further, to address the gap in the BoP literature, a phenomenological study with a primarily qualitative, inductive approach to research has been chosen. This comprehensive design facilitates descriptive detail and holistic understanding of phenomena, which is able to deal with a high level of subjectivity (Bryman and Bell, 2011; Creswell, 2009). In addition, the case study method is used to collect information from multiple sources of evidence (Yin, 2009), and grounded theory is incorporated to facilitate collection, analysis and coding of raw data. Ultimately, the empirical results of the research study are compared against the existing framework to achieve analytical generalisation (Bryman and Bell, 2011; Glaser and Strauss, 1967; Strauss and Corbin, 1998).

1.1 THE BOP LITERATURE

As the BoP literature has expanded over the last decade, four general definitions within the literature have emerged. For instance, BoP can refer to a demographic of people (London and Hart, 2011; Prahalad, 2010; Simanis, 2010), a global consumer market (Hammond et al., 2007; Prahalad, 2010; Prahalad and Hammond, 2002; Prahalad and Hart, 2002), an approach to global strategy (London and Hart, 2004) and a new perspective on poverty alleviation (London, 2007 (July); Prahalad, 2004; Prahalad and Hart, 2002). Although the definitions are relatively interrelated, clear distinctions can be made regarding each area.

The BoP demographic is demarcated by income as well as other social characteristics. Regarding size of the BoP demographic and income parameters, Prahalad and Hart (2002) initially suggested there are approximately four billion people in the world that live on less than \$1,500 (2002 purchase power parity – PPP) per capita. However, the per capita amount was later revised to \$3,000 PPP per capita in 2002 U.S. dollars (\$3,260 PPP in 2005 U.S. dollars) (Hammond et al., 2007). Further, many authors have outlined social characteristics that define the BoP demographic such as low levels of literacy, significant unmet needs, dependence upon subsistence livelihoods, existence in the informal or extralegal economy and subjectivity to the poverty penalty (De Soto, 2000; Hammond et al., 2007; Viswanathan, 2011).

Social characteristics are important to understand because the BoP demographic represents the world population excluded from global capitalism and a demographic of people who typically conduct business in the extralegal economy. For example, people living in the BoP demographic often lack access to markets to secure employment or sell crops or handicrafts. As a result, workers are often exploited by local employers or middlemen. Further, most people living in the BoP demographic typically lack access to financial services such as bank accounts and credit, live in informal settlements and have no legal title to land. Thus, due to lack of access to enforceable contract law, property titles and live capital, people living in the BoP demographic tend to transact business in the extralegal or shadow economy (De Soto, 2000; Hammond et al., 2007; Schneider et al., 2010).

As a result of the immense size of the BoP demographic, Prahalad and Hart (2002) proposed that this demographic represents an untapped, multi-trillion dollar consumer market. Consequently, it is important to understand the general context of the BoP market. For instance, although BoP markets typically lack various legal resources such as enforceable business contracts or land titles, they are rich in other areas such as

interpersonal relationships and local knowledge among individuals transacting business within the market (De Soto, 2000; Viswanathan, 2007). Thus, in the absence of financial assets or live capital, BoP markets thrive on social capital. Unlike hard assets, this type of capital is created when members of a community invest time, effort and reputation into relationships within the community (De Soto, 2000; Ritchie and Sridharan, 2007).

There are significant business opportunities that exist in the BoP market, but this diverse market is wrought with various barriers that frequently constrain business activity among market participants. For instance, the literature includes barriers such as access, infrastructure, skills and capabilities and government. In addition, BoP market participants generally lack access to labour markets, relevant market information and diverse financial services. The barriers arise partly due to the absence of conditions that enable markets to operate efficiently (e.g. legal contracts, land titles) and make it difficult for producers and consumers alike to actively participate and succeed in BoP markets (Gradl et al., 2008; Mendoza and Thelen, 2008).

Although barriers present ongoing challenges for market participants transacting business in the BoP market, multinational corporations (MNCs) have begun to recognise the potential of developing these untapped markets. In particular, MNCs have pursued growth in emerging markets (EMs) such as China, India, Brazil and Russia as growth rates have slowed in more developed markets (e.g. North America and Europe). However, MNCs typically have focused on wealthy consumers at the top of the economic pyramid and the rising middle class in emerging markets rather than the BoP market (London and Hart, 2004; Prahalad and Lieberthal, 1998). For these corporations, targeting BoP markets presents a new global opportunity beyond traditional approaches to seeking new markets in developing countries. Therefore, the BoP approach addresses how MNCs develop global strategy to successfully target and penetrate BoP markets.

The BoP market does not merely represent a new, untapped market for large corporations to exploit. Rather, BoP researchers contend that organisations can simultaneously earn profits and alleviate poverty (London, 2007 (July); London et al., 2010; London and Hart, 2004; Prahalad, 2004, 2010; Prahalad and Hammond, 2002; Prahalad and Hart, 2002). Prahalad and Hart (2002) call the simultaneous focus on global business strategy and poverty alleviation inclusive capitalism, and London et al. (2010) argue that this dual focus, or mutual value creation, is crucial to successfully penetrating BoP markets. Thus, the BoP perspective is a new and unique perspective on

poverty alleviation, and the simultaneous pursuit of profits and poverty alleviation is the hallmark of this perspective.

It is important to clarify the four areas within the BoP literature to reduce ambiguity and facilitate development of the current research study. For instance, segmentation of the BoP market is necessary for establishing context for the research study. Therefore, the current study examines segmentation by income, region, country and sector. Income segmentation is crucial since the BoP market is not a homogenous mass market (Hammond et al., 2007), segmentation by region and country are explored due to the geographical location in which the research study takes place (e.g. Afghanistan) and segmentation by sector is included because the current research study is conducted within the health sector.

1.2 SEGMENTING THE BOP MARKET

As previously mentioned, there are approximately four billion people living in the BoP demographic that earn less than \$3,000 (in 2002 PPP) per capita, and it is estimated that the global market potential of the BoP market at five trillion dollars (Hammond et al., 2007). However, leading authors agree that the BoP market is not a homogenous mass market and that differences can fluctuate widely among various segments. As a result, segmentation of the BoP market is essential to establish context for the current research study. Thus, the research study examines market segmentation by income, region, country and sector.

First, the BoP market can be segmented into six different income segments – BOP500, BOP1000, BOP1500, BOP2000, BOP2500 and BOP3000 – and characteristics describing education, skills and needs can be identified within various segments. For instance, while families in higher income segments may strive for higher education, better housing and access to credit, those in lower income segments face very limited educational opportunities and lack even basic necessities such as sufficient food and access to clean water (Hammond et al., 2007; Rangan et al., 2011).

Second, regional segmentation is included because the research study takes place in Afghanistan, which is part of Central Asia, and the BoP market in the Asia region differs in various ways from other regions such as Eastern Europe or Latin America (Hammond et al., 2007). Further, close analysis of the BoP market in Asia provides a starting point for understanding BoP market composition in Afghanistan. While assessing segmentation at the regional level is important for the research study, Asia is a very large region and BoP markets vary across different countries.

Therefore, the third way the BoP market is segmented is by country. Because no data on the BoP market is available for Afghanistan, it is necessary to explore BoP markets within the neighbouring countries that are closest in proximity and culture to Afghanistan. These countries include Bangladesh, India, Nepal, Pakistan, Tajikistan and Uzbekistan (Hammond et al., 2007). Although BoP markets in these countries do not exactly mirror the BoP market in Afghanistan, analysing the BoP market within these nations provides a reasonable picture of what it might look like in Afghanistan.

Finally, the context of the current research study is focused on assessment of a BoP venture in the health sector in Afghanistan. Therefore, it is important to also investigate how the BoP market can be evaluated by sector. The research study explores several sectors within the BoP market such as food, water, housing, energy and health (Hammond et al., 2007). Analysing numerous sectors is important because they

range widely in size and composition and help provide a clearer picture of spending patterns within the BoP market.

Consequently, market segmentation develops context for the research study by estimating both the country-level BoP market as well as the BoP health sector in Afghanistan. As a result, the composition of each (e.g. BoP market and BoP health sector in Afghanistan) is explored, which includes parameters such as market size, segmentation and spending patterns. However, to better understand how impact might be measured in the health sector in Afghanistan, a more comprehensive description of health care in Afghanistan is needed. This is necessary because the dynamics of the health care sector in Afghanistan are unique and still in the developmental stages due to ongoing reconstruction of the country.

1.3 HEALTH CARE IN AFGHANISTAN

In addition to segmenting the BoP market and health sector in Afghanistan, an in-depth understanding of health care in the country is needed to provide context for the research study. For instance, during the last several decades, the provision of health care in Afghanistan has been impacted by a series of conflicts that devastated the government, economy and infrastructure. As a result, Afghanistan has had some of the worst health statistics in the world, especially in regard to women and children. During the 1980s and 1990s, the majority of health care in Afghanistan was provided by NGOs (non-governmental organisations) that worked cross-border from Pakistan. However, there was no central health care policy in Afghanistan, and the delivery of primary health care services was extremely limited and unevenly distributed throughout the country. This was the general context in which the international community entered Afghanistan after the Taliban was driven from the country in 2001 (Loevinsohn and Sayed, 2008; Waldman et al., 2006).

Following the fall of the Taliban, the transitional government of Afghanistan (in cooperation with the international community) established public health care policy for the country. The new health care policy included a standardised package of basic services to be provided in all primary health care facilities in Afghanistan in order to promote equitable access to health care services. Services initially incorporated in the package include maternal and newborn health, child health and immunisation, public nutrition, communicable diseases, mental health, disability and supply of essential pharmaceuticals (Loevinsohn and Sayed, 2008; Strong et al., 2005; Transitional Islamic Government of Afghanistan, 2003; Waldman and Hanif, 2002). To actually deliver the health care services across the country, the Afghanistan government contracted with NGOs that were funded by the World Bank, USAID and European Commission (Newbrander et al., 2011; Roberts et al., 2008; Sabri et al., 2007).

Although the government of Afghanistan and international community focused their efforts on creating and organising the public health sector in Afghanistan, a sizeable private sector has emerged alongside the public sector. The development of the private health sector has been partly due to the lack of coverage and weaknesses in the public sector, which has resulted in the emergence of numerous private sector providers. While the private health sector has grown significantly, attempts to coordinate and regulate the sector have had limited success (Pavignani and Colombo, 2002; Steinhardt et al., 2009).

Overall, there is limited data on the private health sector in Afghanistan, and literature regarding the private health sector is often fragmented among various reports written by NGOs or development agencies. However, as the private health sector in Afghanistan has developed over time, information regarding the various types of private health providers and services provided by private providers has emerged. For instance, private health care providers include formally established facilities such as hospitals, clinics, pharmacies and laboratories. In addition, many physicians have their own private practices, which may be in a small office or the physician's home. Nurses, midwives and birth attendants may also practise in the private sector. Traditional healers, such as Mullahs, are even considered part of the private sector. However, they typically rely upon religious or superstitious methods (Alsi et al., 2009; Pavignani and Colombo, 2002; Steinhardt et al., 2009).

Although one-stop care is not common within the private sector, the services provided by private sector providers are often more specialised than in the public sector. As a result, there tends to be clusters of related services among the various private sector providers such as primary health services, basic maternal health services and prescription or drug services. Primary health services include services such as routine physical examinations, diagnosis and prescription of medication. Basic maternal health services include antenatal care, delivery and postnatal care. Prescription and drug service providers diagnose conditions, prescribe medications and provide the drugs (Alsi et al., 2009).

Consequently, there is an overlap between the public and private health sectors in Afghanistan, and it appears that the services provided by the public and private sectors are more complementary than competitive. For instance, there are different reasons for visits to public and private health clinics, particularly regarding gender and age. The majority of households where children need routine health care tend to visit providers in the public sector whereas the majority of adults seeking routine care typically visit providers in the private sector. Reliance upon public and private providers tends to further vary from province to province, which reflects preferences and accessibility of each type of provider. Thus, the overlap between the two sectors appears to be more of a positive development rather than a systematic problem (Alsi et al., 2009).

Utilisation, quality of care, patient satisfaction and cost of care are additional areas of comparison necessary for understanding the similarities and differences between the public and private health sectors. For example, although the public and

private health sectors are somewhat complementary, there appears to be a growing trend towards utilisation of private sector providers (Afghanistan Ministry of Public Health, 2004, 2006; Alsi et al., 2009; Trani et al., 2010). Studies further reveal that quality of care and patient satisfaction impact utilisation and appear to be relatively comparable between public and private providers (Ameli and Newbrander, 2008; Gupta, 2008; Singh et al., 2012). Cost of care is also a critical consideration because cost has been linked to utilisation, quality of care and patient satisfaction. In general, private providers appear to charge reasonable prices but are more expensive than public providers (Chawla and Ellis, 2000; Peters et al., 2008; Rao and Peters, 2007).

In conclusion, the literature review concerning health care in Afghanistan is required because no research is available in the BoP literature concerning the BoP market or health sector in Afghanistan. Reviewing this field of literature is further necessary because the organisation involved in the research study has been a private provider of health care services in Afghanistan since 2003. Thus, understanding Afghanistan's history regarding health care delivery, development of the public health care sector, the emerging private health care sector and overlap between the two sectors is essential for developing the context for the research study and addressing the gap in the BoP literature.

1.4 GAP IN THE BOP LITERATURE

The BoP field is still relatively new (only about a decade old), and there have been significant advancements throughout the literature regarding the BoP demographic, BoP market, BoP approach and BoP perspective. Although the overall BoP field has grown substantially, there are still areas in need of further development. For instance, much of the literature concerning the BoP perspective is based upon numerous ventures that have been launched during the last decade. However, comprehensive, empirical assessment of BoP venture impact upon poverty alleviation in the literature is virtually non-existent (London, 2009b). Impact assessment therefore represents a significant gap in the literature that should be developed further.

While assessment is lacking in the BoP literature, there is one framework that has been developed to comprehensively assess impact of BoP ventures. Therefore, using the BoP Impact Assessment Framework developed by London (2009b), the gap in the literature is addressed through an empirical research study of a BoP venture targeted at the BoP market in Afghanistan. The research study is designed to test the existing framework in a unique context – the BoP health sector in Afghanistan. As a result, it is important to thoroughly establish the background, or context, for the study in two areas.

First, using income as the focal point, BoP market segmentation by region, country and sector is provided. Estimates are determined for the Afghanistan BoP market because no data is available for the country. Second, because the BoP literature provides no information concerning health care in Afghanistan, more detailed knowledge concerning the Afghanistan health care literature is required. For instance, utilisation, quality of care, patient satisfaction and cost are central themes within the Afghanistan health care literature that affect how assessment might be measured (Alsi et al., 2009; Trani et al., 2010).

In summary, defining, exploring and integrating the BoP literature and the Afghanistan health care literature is important for identifying and addressing the gap in the BoP literature regarding assessment and establishing context for the research study. Although impact assessment represents a clear gap in the BoP literature that is in need of further development, an existing framework has been identified as the basis for the study design. Therefore, the BoP Impact Assessment Framework provides a general theoretical framework for designing the study, which is required to address the gap in the BoP literature.

1.5 STUDY DESIGN

In order to test the BoP Impact Assessment Framework, the research study is conducted in a unique context – the health care sector in Afghanistan. Thus, the study is designed to test the theoretical framework within this context. For instance, the research question, aim and objectives are designed around general themes covered by the BoP Impact Assessment Framework, which include economic impact and social impact. Further, the framework is tested in regard to its effectiveness for organisations to understand and improve impact of BoP ventures. By including understanding and improving impact, the research question, aim and objectives explore what, how and why phenomena occur.

Consequently, to address the research question, aim and objectives, the phenomenological research paradigm is required, which is consistent with a qualitative, inductive approach to research. Phenomenology is a more holistic approach than positivism because it is able to provide rich explanation and understanding of multiple complex phenomena, which is important given the context of the research study. Similarly, qualitative research has a greater potential to provide descriptive detail and holistic understanding of phenomena compared to quantitative research. Thus, it takes a more holistic view of phenomena and is better suited to deal with a higher level of subjectivity (Bryman and Bell, 2011; Creswell, 2009).

The research methodology includes both empirical and field-based research, which are frequently used methodologies throughout the BoP literature (London, 2005, 2009b; London and Hart, 2004; London et al., 2010; Simanis, 2010; Viswanathan et al., 2009). Further, the case study method is used because it effectively addresses what, how and why questions. This research method is also appropriate when the researcher has little control over events and the research emphasis is on real-life, contemporary phenomena, which is essential for the current study (Yin, 2009). In addition, use of the case study method in the BoP literature is prolific (Anderson and Markides, 2007; London et al., 2010; Prahalad, 2002, 2010; Prahalad and Hammond, 2002; Prahalad and Hart, 2002; Seelos and Mair, 2007; Simanis and Hart, 2006; Wheeler et al., 2005).

Triangulation is achieved by relying upon multiple sources of evidence (e.g. documentation, direct observations and interviews) within the case study method. The purpose of collecting information from multiple sources is to corroborate the same facts or phenomena around converging lines of inquiry. For example, data is triangulated when events or facts are supported by more than a single source of evidence. Collecting data from multiple sources of evidence is important because any case study finding or

conclusion is more accurate and credible if it is based upon more than a single source of evidence. Further, the data from multiple sources of evidence is collected in three stages using theoretical sampling, which guides actual data collection such as the selection of research participants. Theory is developed through theoretical sampling by collecting, coding and analysing data into concepts and categories until theoretical saturation of each category is reached (Bryman and Bell, 2011; Glaser and Strauss, 1967; Yin, 2009).

Data analysis is conducted through grounded theory, and results are generalised through analytical generalisation. For instance, grounded theory is derived from data that is systematically collected and analysed through the research process, and grounded theory represents an iterative process because data collection and analysis are carried out concurrently. Although grounded theory is a primarily inductive process that allows theory to emerge from the raw data, a research study may begin with an existing theory if the purpose of the study is to elaborate and extend that theory (Strauss and Corbin, 1998; Yin, 2009). Analytical generalisation is therefore achieved by generalising empirical results, or theory, against the BoP Impact Assessment Framework.

1.6 RESULTS

Morning Star Development (MSDEV) is the organisation involved in the research study, and results pertain to research regarding the Tangi Saidan health clinic near Kabul, Afghanistan. Three primary categories emerged from the empirical results of the research study – “lower health care costs”, “relationships” and “behaviours”. The category “lower health care costs” represents economic impact of the Tangi Saidan health clinic, and the categories “relationships” and “behaviours” characterise social impact of the clinic. Thus, overall impact is integrated into one central category – socio-economic impact. The central category represents all action and interaction concerning the research study and integrates the three main categories to comprehensively capture the entire story. In addition, the central category also relates back to the research question, aim and objectives, which includes understanding and improving economic and social impact.

Each of the main categories that emerged during the research study is separated into two subcategories. For example, the category “lower health care costs” includes the subcategories the clinic visit and health education. The second category, “relationships”, comprises the subcategories interethnic relationships and family relationships. The final category, “behaviours”, includes the subcategories maternal health and hygiene and first aid. Further, each subcategory is composed of several concepts that describe economic and social phenomena discovered during the research study. Thus, the empirical results (inductive theory) are characterised by the categories, subcategories and concepts that emerged from the raw data during the research study.

There were four primary concepts that emerged within the clinic visit subcategory. These concepts represent economic impacts that have collectively resulted in lower health care costs for the people served by the Tangi Saidan health clinic. The four concepts that comprise the economic impact from the clinic visit are transportation, lost wages, accommodation and gifts (nazrana). In general, these economic impacts are associated with travel to Kabul if there was no clinic in Tangi Saidan. For instance, transportation costs are high and patients would miss at least one full day of work to travel to Kabul to seek medical attention. On the other hand, patients typically walk to the Tangi Saidan health clinic and normally do not miss any work.

The second subcategory regarding “lower health care costs” is health education, and this subcategory is comprised of the concepts breastfeeding, maternal mortality and family size. The health education services have impacted the surrounding villages both socially and economically. Unlike the clinic visit above, the economic impact from

health education is not as easily or clearly quantified. For instance, greater knowledge regarding the benefits of breastfeeding has decreased women's reliance on expensive alternatives such as infant formula, and improved delivery methods and healthier cultural practises have reduced the trauma and financial burden associated with maternal mortality. However, because the impact of health education is related to behavioural change rather than a distinct event, the economic impact of health education may possibly be further reaching (albeit less tangible) than the clinic visit.

The two subcategories regarding "relationships" were interethnic relationships and family relationships. Several concepts relating to interethnic relationships emerged during the research study including the second public meeting place, the role of women and impact of the shura. The three concepts collectively describe how the health clinic has caused interethnic relationships to improve over time. For example, the health clinic acts as a second type of public meeting place in addition to the mosque. However, because women are not allowed to visit the mosque, there was no central location in the villages surrounding Tangi Saidan where they could meet in public before the health clinic was established. Therefore, the health clinic acts as the only public meeting place for women in the Tangi Saidan region. This has facilitated social interaction among women from the various ethnic groups and resulted in improved interethnic relations among tribes.

Family relationships is the second subcategory regarding "relationships", and it comprises the concepts family dynamics and the independence of women. These concepts jointly explain how the health clinic has impacted relationships within the family. For instance, family dynamics have changed primarily as a result of the clinic staff providing family planning services. On the other hand, women have begun to experience greater independence as a result of the overall high quality of services provided at the clinic and the trust the clinic staff has established with families living in the surrounding villages. Consequently, the health clinic has impacted various social phenomena such as the number of children desired by parents, the aspirations of family members and the way families interact.

The final category is "behaviours" and includes the subcategories maternal health and hygiene and first aid. The subcategory maternal health comprises several concepts including birth control and spacing, antenatal care and birth and delivery. Birth control and spacing are interrelated areas that have been impacted by the health education provided by the MSDEV medical staff, and this concept reveals insights concerning how the mentality (and subsequent behaviours) of families has changed

concerning the frequency and number of births desired. Maternal health has also been impacted as the clinic staff has educated mothers about nutrition, working during pregnancy and vaccinations. Finally, the concept birth and delivery comprises various social phenomena that have impacted overall maternal health including greater knowledge of the overall birth process, involvement of trained medical professionals and improved delivery methods.

The second subcategory relating to “behaviours” is hygiene and first aid, and it includes the concepts general hygienic practises and the treating of wounds. The concepts describe information taught by the clinic staff concerning general hygiene as well as the teaching and provision of first aid at the clinic. For instance, hygienic practises taught by the clinic staff include hand washing, water and toilet usage, cleaning vegetables and handling garbage. Teaching patients about general hygiene is an important element of the preventative services provided by the health clinic, and first aid generally pertains to how the health clinic has positively impacted the traditional practise of dressings wounds.

In summary, inductive theory that emerged from the raw data is characterised by the categories, subcategories and concepts expounded throughout the Results chapter. For instance, the first category, “lower health care costs”, includes the subcategories the clinic visit and health education; the second category, “relationships”, comprises the subcategories interethnic relationships and family relationships; and the third category, “behaviours”, includes the subcategories maternal health and hygiene and first aid. The first category represents economic impact of the Tangi Saidan health clinic, and the second and third categories characterise social impact of the clinic. Thus, overall impact is integrated into one central category – socio-economic impact. The central category integrates the three main categories and relates back to the research question, aim and objectives, which includes understanding and improving economic and social impact. Therefore, it is important to ultimately evaluate results (e.g. economic and social impacts) along two dimensions – magnitude and likelihood (London, 2009b). Reviewing and assessing economic and social impacts is essential to holistically understand and improve impact and draw conclusions from the research study.

1.7 CONCLUSION AND IMPLICATIONS

While the Results chapter is designed to address the research question, aim and objectives and test, elaborate and extend the existing theory, the Conclusion chapter draws conclusions about the results for the purpose of generalisation. Because the case study does not represent a sampling unit, generalisation from the research study results is achieved through analytical rather than statistical generalisation. This type of generalisation relies upon an existing theoretical framework with which to compare the empirical results (e.g. the inductive theory generated by the raw data). Thus, as recommended by Yin (2009), the research study generalises the results, or theory, to the broader theory (BoP Impact Assessment Framework).

To generalise results, the actual categories from the BoP Impact Assessment Framework are compared against the categories, subcategories and concepts (theory) that were inductively generated from the research study. For example, the existing categories on the BoP Impact Assessment Framework include “potential changes in economics”, “potential changes in capabilities” and “potential changes in relationships”. Alternatively, the categories inductively generated during the research study include “lower health care costs”, “relationships”, and “behaviours”. To achieve analytical generalisation, comparisons are made between the pre-existing categories on the BoP Impact Assessment Framework and the categories that were inductively developed during the research study. As a result of generalisation, content contributions to the BoP literature regarding academic understanding of private sector developmental interventions include support for the central premise of the BoP concept (e.g. how BoP ventures are helping the poor) and support for the BoP Impact Assessment Framework.

The conclusions drawn from empirical results of the research study have several academic and business implications, which are addressed in the Implications chapter. First, academic implications relate to how the research study addresses the gap in the BoP literature and provide content contributions regarding academic understanding of private sector developmental interventions. However, there are several limitations to the current research study, and opportunities exist for future research. Second, there are a number of business, or professional, implications resulting from the research study. The business implications primarily relate to organisations currently pursuing or planning to pursue assessment of BoP ventures. For instance, various professional implications drawn from the research study include assessment best practices, socio-cultural considerations, understanding the target market, innovating or developing the business model and communicating with stakeholders.

CHAPTER: 2 LITERATURE REVIEW

2.1 DEFINING BOP

2.1.1 Overview of the Terminology

In the literature, the terminology bottom of the pyramid or base of the pyramid is still relatively new with its inception in 2002. The first two published articles that introduced the bottom of the pyramid were *The Fortune at the Bottom of the Pyramid* (Prahalad and Hart, 2002) and *Serving the World's Poor, Profitably* (Prahalad and Hammond, 2002). Since the publishing of these major articles, the body of literature has grown and numerous researchers have joined the discussion. Subsequently, authors changed the initial terminology bottom of the pyramid to base of the pyramid to represent more of a bottom-up view (Prahalad, 2010).

The terms bottom and base are used interchangeably throughout the literature (this research study uses base as the appropriate term), and the base of the pyramid is often abbreviated as simply BoP. The majority of authors use either the term bottom or base. Some authors use the terminology subsistence marketplaces in place of bottom of the pyramid or base of the pyramid (Chikweche and Fletcher, 2010; Viswanathan and Rosa, 2007; Viswanathan et al., 2010). There is some ambiguity concerning how the term BoP is used throughout the literature. Further, there is no broad discussion in the literature focusing on reconciling the various definitions. Rather, BoP is widely interpreted in several ways, and the different meanings are commonly accepted throughout the literature.

BoP is used in four primary ways in the literature. First, BoP is referred to as a socioeconomic demographic of people (London and Hart, 2011; Prahalad, 2010; Simanis, 2010). Second, it is defined as a global consumer market such that the purchasing power of the people living in the BoP demographic can be aggregated, and the market can be segmented (Hammond et al., 2007; Prahalad, 2010; Prahalad and Hammond, 2002; Prahalad and Hart, 2002). Third, the BoP is described as an approach to global strategy in which distinct business strategies are needed to support ventures or initiatives targeting the BoP market (London and Hart, 2004). Fourth, the BoP is heralded as an alternative approach or a new perspective on poverty alleviation that can be distinguished from other traditional approaches to poverty alleviation (London, 2007 (July); Prahalad, 2004; Prahalad and Hart, 2002).

The early BoP proponents paved the way for the baseline understanding of the BoP demographic and BoP market in the literature. However, BoP demographic and

BoP market are typically used concurrently without clear distinction between the two definitions. The result is that the two terms are essentially indistinguishable (Ahmed, 2007; Guillermo, 2007; Jaiswal, 2008; Mohr et al., 2012; Prahalad, 2004, 2010; Prahalad and Hart, 2002; Toledo-López et al., 2012; Van den Waeyenberg and Hens, 2012). As mentioned above, some authors use subsistence marketplaces instead of BoP. However, they still do not clearly distinguish between the demographic of people and the consumer market (Chikweche and Fletcher, 2010; Crawford-Mathis et al., 2010; Viswanathan and Rosa, 2007; Viswanathan et al., 2010). These interrelated terms have yet to be distinctly differentiated in the literature.

Once the BoP was established as a demographic of people and a global consumer market, leading authors increasingly focused on the BoP as an approach to global strategy and a unique perspective on poverty alleviation (London, 2007 (July); London, 2010; London and Hart, 2004; Prahalad, 2004; Prahalad and Hammond, 2002; Prahalad and Hart, 2002). They advocate that companies focusing strategies at the BoP market could simultaneously earn profits and alleviate poverty. Prahalad and Hart (2002) call this dual focus on global strategy and poverty alleviation inclusive capitalism.

Therefore, the terms BoP demographic, BoP market, BoP approach and BoP perspective are used throughout the thesis to clarify the various definitions of BoP. Additionally, the terms BoP venture and BoP initiative are used interchangeably in the literature to describe how organisations target the BoP market. A BoP venture or initiative simultaneously creates value for the organisation and people living in the BoP demographic by interfacing with the private sector and leveraging market-oriented tactics (London, 2007 (July); London, 2010; London and Hart, 2004; Prahalad and Hart, 2002; Simanis, 2010). Various development organisations use terms such as growing inclusive markets, inclusive business or opportunities for the majority to describe ventures targeting BoP markets (Gradl et al., 2010; IDB, 2012; Ishikawa et al., 2012). However, BoP venture is the term generally referred to in the BoP literature to describe organisational efforts targeting the BoP market.

2.1.2 BoP Demographic and BoP Market

2.1.2.1 Size and Parameters of the BoP Demographic and BoP Market

Prahalad and Hart (2002) were the first to use the term BoP to simultaneously represent a demographic of people and a global consumer market. They demarcated the BoP demographic by income as well as other social characteristics. In regard to income,

Prahalad and Hart (2002) originally suggested there are approximately four billion people in the world that live on less than \$1,500 (2002 purchase power parity – PPP) per capita, and they proposed that multinational corporations (MNCs) should view the BoP demographic as an untapped, multi-trillion dollar consumer market. Prahalad (2004) later advocated that the global market potential of the BoP market is more than \$13 trillion PPP. Figure 2.1 segments the world economic pyramid.

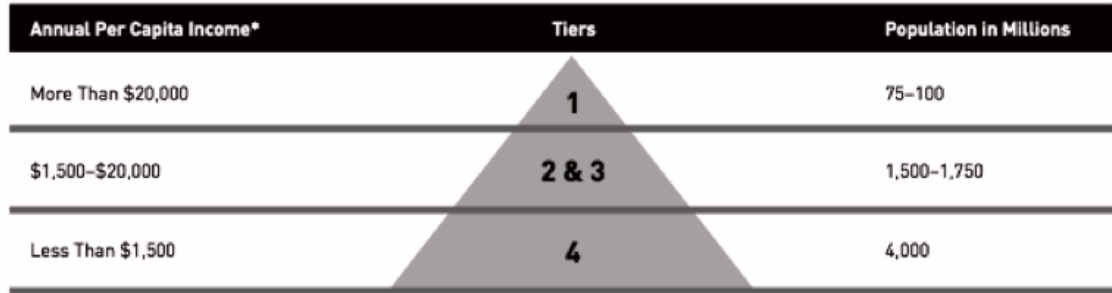


Figure 2.1: World Economic Pyramid (SOURCE: Prahalad & Hart, 2002)

Karnani (2006, 2007) challenged the initial income parameters of the BoP demographic and the global market potential of the aggregate BoP market. He argued that the number of people living in the BoP demographic and the estimated global market potential of the BoP market were overstated. He suggested that there are only approximately 2.7 billion people living in the BoP demographic and that the global market potential of the BoP market is less than \$0.3 billion (in 2002 PPP). However, these early criticisms were superseded by a joint study conducted by the World Resources Institute (WRI) and International Finance Corporation (IFC) regarding global income demographics (Hammond et al., 2007).

By using global household survey data from 110 countries, the WRI-IFC study found that there are approximately four billion people living in the BoP demographic that earn less than \$3,000 PPP per capita in 2002 U.S. dollars (\$3,260 PPP in 2005 U.S. dollars) (Hammond et al., 2007; London and Hart, 2011). Hammond et al. (2007) note, however, that incomes (in 2005 U.S. dollars) vary regionally such as less than \$3.35 per day in Brazil, \$2.11 per day in China, \$1.89 per day in Ghana and \$1.56 a day in India. Consequently, using the empirical data provided by the WRI-IFC study, some authors estimate that the four billion people living in the BoP demographic earn less than \$5.00 per day (Rangan et al., 2011; Simanis, 2010) while others suggest a more conservative estimate of less than \$8.00 per day (Jenkins et al., 2008; WEF and BCG, 2009).

The joint WRI-IFC study further estimated the aggregate global market potential of the BoP market at five trillion dollars. In addition, the study segmented the BoP market into six income segments including the BOP500, BOP1000, BOP1500,

BOP2000, BOP2500 and BOP3000 (Hammond et al., 2007). These income and market definitions are helpful. However, London and Hart (2011; pg. 7) caution that over-emphasising PPP demarcation lines *...ultimately guides the conversation into an arena of diminishing returns*, and that attempting to precisely calculate market size is *...fraught with difficult-to-defend assumptions and questionable attempts at pseudoprecision*. Therefore, the PPP demarcation lines should be *...viewed as sources of empirical and illustrative convenience, rather than as a rigid definition* because income provides a relatively narrow perspective concerning a more complex phenomenon.

Instead of focusing on rigid income demographics, London and Hart (2011) propose that the BoP demographic represents the world population excluded from global capitalism and a demographic of people who conduct business in the extralegal or informal economy. Moreover, Simanis (2010) claims that the debate over income and market potential provides limited value when crafting strategy to reach diverse BoP markets. Therefore, additional characteristics that depict the diverse population living in the BoP demographic should be considered.

2.1.2.2 Social and Legal Environment of the BoP Demographic

Social characteristics that define the BoP demographic include low levels of literacy, significant unmet needs, dependence upon subsistence livelihoods, existence in the informal or extralegal economy and subjectivity to the poverty penalty. The existence of low levels of literacy is one of the most fundamental social characteristics of the BoP demographic. This is because low literacy often leads to social and cognitive vulnerabilities and can reduce entrepreneurial capacity, which often are contributing factors to the cycle of poverty. Further, low literacy is important for understanding the BoP demographic because it may lead to certain ways of thinking (Viswanathan, 2011; Viswanathan and Sridharan, 2009).

One type of thinking that may result from low literacy is called concrete thinking. This type of thinking focuses on a single piece of information without integrating additional sources of evidence. People engaging in this type of thinking style may overly focus on isolated pieces of information without understanding the full meaning. Pictographic thinking is a second style of thinking common among low literate individuals living in the BoP demographic. Individuals resorting to this type of thinking rely upon a relatively straightforward form of processing information, which may involve viewing text as images or pattern matching to identify objects. As a result

of low literacy, individuals may get locked into short-term thinking and struggle to envision the future. Further, low literacy associated with poverty tends to lower self-esteem. Low literacy carries a stigma such that it is often viewed as the source of an individual's impoverished condition (Viswanathan, 2011; Viswanathan and Sridharan, 2009; Viswanathan et al., 2008a).

It should be noted, however, that although the abovementioned authors found the various characteristics during their research, it should not be assumed that low literacy would have the same effect upon the thinking patterns of every individual across the vast BoP demographic. In addition to low literacy, people living in the BoP demographic typically face unmet needs regarding adequate nutrition, clean water and basic health care. Some living in the BoP demographic depend upon subsistence livelihoods such as farming or fishing. The subsistence and small-scale farmers and fishermen tend to be particularly susceptible to environmental destruction yet often lack the ability to protect critical natural resources. If there is a disaster such as a drought or flood, they may not be able to provide even the most basic necessities for their families (Hammond et al., 2007).

From Viswanathan's (2007) research on the BoP demographic in South India, he discovered common themes in regard to basic living conditions including the family residence, transportation, nutrition, education, health care and employment. Families typically live in small rented dwellings such as a mud hut or basic concrete structure, and the family residence commonly lacks sufficient infrastructure and access to utilities such as water, sanitation and electricity. Transportation includes walking, bicycles, public buses or motorised two-wheelers, and options are limited in rural areas. Nutrition is often deficient, and rice is the staple diet for families.

Nutrition varies among families and depends on income. Rice is the staple, and in addition, families may purchase lentils, spices, vegetables and meat to eat with the rice. Education is very important, and many families will make sacrifices so children can get the best education. However, education may not be as accessible in rural areas compared to urban cities. Health care is provided by government and private providers, but many people do not seek medical attention until health has deteriorated to the point of negatively impacting earning ability. Men often run small businesses or are employed as day workers in construction or agriculture, and women are commonly employed as housemaids (Viswanathan, 2007).

It is common for workers to be exploited by local employers or middlemen because they often lack access to markets to secure employment or sell crops or

handicrafts. Most people living in the BoP demographic have no bank account and typically lack access to financial services such as credit. Many live in informal settlements and have no legal title to their land. It can take months to officially register a business and years to legally purchase a home with a title to the land. One study in Peru found that it took 289 days to register a business and almost seven years to obtain legal authorisation to build a house on state-owned land. The same study found that it could require roughly 168 steps involving 53 public and private organisations and take between 13 to 25 years to legally purchase a home built on a settlement on private or state-owned urban land in the Philippines. As a result of the insurmountable legal obstacles, very few people living in the BoP demographic own a legal title to their land. Without legal title to land or homes, assets cannot be valued and are dead capital. In other words, these unregistered or dead assets cannot be converted to live capital (De Soto, 2000; Hammond et al., 2007).

Therefore, due to lacking access to enforceable contract law, property titles and live capital, people living in the BoP demographic tend to transact business in the extralegal or shadow economy. The extralegal economy is outside of the formal, legal economy, and people transact business in the extralegal economy as a result of the multiplicity of legal obstacles that must be overcome to conduct business in the formal economy. Because of these barriers, the only alternative for many poor people living in the BoP demographic is to informally create their own binding agreements to protect and leverage their assets. These extralegal agreements are held together by a social contract rather than legally binding contract. Whereas courts and legal authorities interpret and enforce legal contracts, the social contract is upheld by the community and enforced by authorities chosen by the community (De Soto, 2000; Hammond et al., 2007; London and Hart, 2011; Prahalad, 2010; Schneider et al., 2010).

Extralegal or shadow economies comprise a significant percentage of the overall economy for many nations, and business owners in industries ranging from agriculture to real estate transact business in this informal environment. For example, onerous legal procedures for changing land tenure in Peru have resulted in farmers illegally subdividing land into smaller private plots. Similarly, legal tenants of apartments in Cairo whose rents were frozen in the 1950s subdivide properties into smaller apartments and lease them out at market prices. Other residents of older public housing projects build illegal stories on top of their buildings and sell apartments to relatives and other buyers. Often business activity that originates in the legal system, such as the Cairo rent-controlled apartments, transitions into the extralegal economy due to the increasing

cost and complexity of following the law. Similar examples abound globally, especially in developing countries (De Soto, 2000; Schneider and Enste, 2000).

Although it can be difficult and costly for people living in the BoP demographic to participate in the legal economy, De Soto (2000) proposes that operating in the extralegal economy is also very expensive. In fact, he suggests that transacting business in the extralegal economy is often more costly and full of hassles and inefficiencies compared to the legal economy. This is because conducting business in an extralegal environment may include paying bribes and commissions to authorities, avoiding legal penalties, working from dispersed locations, distributing outside traditional channels and operating without access to credit. Extralegal contracts are typically not enforceable in a court of law, and it is not possible to reduce certainty through limited liability systems or insurance policies when transacting business extralegally. Further, business owners that operate in the extralegal economy often face limited sources for investment capital needed to achieve economies of scale and cannot protect innovations through patents, so they may forfeit potential royalties.

Not only do the poor living in the BoP demographic face a burdensome legal environment, they are also frequently subject to paying higher costs compared to their wealthier counterparts. Prahalad (2010) calls this phenomenon the poverty penalty. The poverty penalty is the result of various factors such as local monopolies, strong local intermediaries, inefficient access and poor distribution. As a result of the poverty penalty, people living in the BoP demographic often pay many times what wealthier individuals pay for the same goods and services such as municipal grade water, rice and credit.

For example, the poor in Dharavi (a low-income neighbourhood in Mumbai, India) commonly pay 600 to 1,000 percent interest for credit from local moneylenders. Comparatively, their wealthier counterparts living in Warden Road (a higher-income neighbourhood in Mumbai, India) pay only between 12 and 18 percent interest for the same access to credit. This means that those in the BoP demographic in Dharavi pay a poverty penalty of approximately 53 times what wealthier individuals from Warden Road pay for the same services. Compared to the wealthy who live in Warden Road, the poverty penalty for the poor in Dharavi is also high for municipal grade water (37 times) but much less for rice (1.2 times). Research indicates the poverty penalty is universal, but the magnitude of the poverty penalty varies by country (Prahalad, 2010).

Overall, the evidence suggests that people living in the BoP demographic face a challenging social and legal environment regarding daily subsistence. Low income,

inadequate nutrition, moderate access to health care, low literacy, poor infrastructure, limited transportation, lack of access to financial services, absence of legally enforceable contracts and cost inequities are common social and legal characteristics of the BoP demographic. Although people living in the BoP demographic tend to share similar social and legal characteristics, the BoP demographic is not a monolith. Rather, this large demographic of approximately four billion people is diverse, and there is significant variability within the broad demographic regarding income levels, literacy, geographic mix, cultural norms and religious differences (Prahalad, 2004). Therefore, it is important to consider the broad social and legal dynamics that characterise the BoP demographic in order to understand the context of the BoP market.

2.1.2.3 Context of the BoP Market

The global BoP market is more than just a new consumer market in which to sell products to consumers. Rather, BoP market participants include individual consumers and their families, producers such as entrepreneurs or local firms and communities. Many consumers are also entrepreneurs, so they play dual roles within the market. Companies from developed markets have traditionally overlooked the BoP market, but now it is recognised as being composed of rich, culture-specific markets in which billions of people conduct commerce (Rangan et al., 2007; Viswanathan and Rosa, 2010).

Therefore, it is important to understand the general context of the BoP market. For instance, social capital is central to how BoP markets operate. Although BoP markets are lacking in various legal resources such as enforceable business contracts or land titles, they are rich in other areas such as interpersonal relationships and local knowledge among individuals transacting in the market (De Soto, 2000; Viswanathan, 2007). Thus, in the absence of financial assets or live capital, BoP markets thrive on social capital. Social capital is created when members of a community invest time, effort and reputation into relationships within the community (De Soto, 2000; Ritchie and Sridharan, 2007).

Coleman (1988) explains that social capital can take four different forms including norms, obligations, trustworthiness and information sharing. Social norms are rules that are generally embraced within a community that encourage certain behaviours and discourage others. Social obligations pertain to reciprocity within the community. For example, a member of the community who performs a favour for another person expects the recipient to return equal performance at a later date. Trustworthiness is the

inherent belief that obligations will be repaid. Information sharing is a form of social capital in which interpersonal connections facilitate the exchange of information leading to action. Therefore, social capital can be regarded as an asset or resource because individuals with high levels of obligations outstanding have social capital on which they can draw within the community.

Many scholars agree that social capital can be viewed as an asset that can be harnessed for economic benefit (Iyer et al., 2005). Therefore, social capital holds several implications for firms. First, social capital is a resource that can be used for promoting business activity and consumption in BoP markets. Second, unlike other forms of capital, social capital facilitates production without being consumed in the process. It is based upon relationships, so it exists and changes along with the underlying relationships. Finally, social capital can be created without an explicit economic motive (Coleman, 1988).

These implications reveal why social capital may be an important resource for firms seeking to serve the BoP market. For example, social capital is a powerful catalyst in markets where cultural norms are more important than formal institutions, which is typical of BoP markets (Mosse, 2006). Although BoP markets often lack various types of resources, most possess some form of social capital. Further, the availability of social capital depends upon an underlying social structure that connects market participants within a particular context. Therefore, building social relationships with BoP market participants can lead to the formation of social capital (Ritchie and Sridharan, 2007).

Social capital is crucial to understanding how BoP markets operate, but there are many other factors that influence how BoP markets function such as low literacy. The level of literacy of producers and consumers within the BoP market impacts virtually all interactions within the BoP market. For example, low literate buyers may not be aware of their consumer rights or lack the confidence needed to make high quality purchasing decisions. They often also lack typical consumer skills including planning, creating lists, reviewing products and checking prices. These low literate consumers may not consider non-monetary or indirect costs when negotiating an exchange (Viswanathan et al., 2008a; Viswanathan et al., 2010).

As mentioned earlier, individuals with a low level of literacy tend to exhibit concrete and pictographic thinking. These thinking styles affect the market interactions between producers and consumers. For instance, concrete thinking may cause consumers to reduce purchasing decisions to single attributes such as price instead of jointly considering price and package size together. Pictographic thinking leads to

viewing brand names as images or matching patterns to guide product and service purchases. Therefore, as a result of low literacy, consumers often do not plan purchases, verify prices, evaluate product quality or switch sellers to obtain better deals. Similarly, low literate producers often do not analyse the market or consider alternatives before launching a venture. They commonly lack basic accounting and finance skills so fail to comprehensively understand business costs or return on investment (Viswanathan, 2007; Viswanathan and Sridharan, 2009; Viswanathan et al., 2008a; Viswanathan et al., 2010).

In addition to low literacy, Viswanathan (2007) describes four distinct product and market interactions that characterise the BoP market. These include uncertainty, complexity and lack of control, one-on-one interactions, make or buy decisions and transactional fluidity. Uncertainty and lack of control within the BoP market often pertain to resource issues such as accessibility of electricity or availability and quality of water. In addition, basic services such as transportation are frequently subject to greater variability and complexity due to number and inconsistency of many uncontrollable factors. Therefore, daily business transactions in the BoP market commonly face considerable uncertainty and complexity over which market players may have little control.

Further, the network rich, 1-1 relationship between producers and consumers is crucial to how BoP markets operate. Interaction and communication between market participants occurs continuously. The producer understands consumer preferences and negotiations between price and quantity are common. Producers rely on direct feedback from customers to determine product mix and inventory levels. Retailers may offer personalised services such as credit or savings plans to people in need. Where services are offered that address community needs, providers may sell products door to door. In the medical field, doctors that provide quality 1-1 services, such as checking pharmacy prescriptions, develop strong patient loyalty. Therefore, where 1-1 interaction is the norm, word of mouth among individual consumers or between producers and consumers drives market transactions (Viswanathan, 2007).

The make-or-buy decision is also common within the BoP market. Because incomes are low among consumers in the BoP market, making a product instead of buying it may be cheaper. Additionally, consumers may choose to make a product for quality reasons or because it allows customisation. For example, Indian consumers may make their own curry spices because it is less expensive or because they are concerned that ingredients in premixed offerings have been tainted. A make-or-buy-or-forego

decision may occur in certain situations, such as in the case where medical treatment is needed. Illnesses often go untreated because the medicine or treatment is too costly and self-treatment or self-medication is not possible (Viswanathan, 2007).

Transactional fluidity is a final component of the BoP market context. Price and quantity are negotiated rather than firmly set, price concessions may be given based upon individual circumstances, weighing of products may vary depending on negotiations and installments may not be paid according to initial expectations. These business transactions are fluid, not firm. Thus, buyers and sellers exercise considerable latitude in regard to product and price variability during and even after negotiations as buyers may refuse to pay future installments or sellers might adjust weights after a price has been negotiated (Viswanathan, 2007).

2.1.2.4 BoP Market Barriers

Unfortunately, the unique context of the BoP market is wrought with various barriers that constrain business activity among market participants. Significant barriers from the literature include access, infrastructure, skills and capabilities and government. These barriers, or constraints, make it difficult for producers and consumers alike to actively participate and succeed in BoP markets. Further, the barriers are not mutually exclusive and arise partly due to the absence of conditions than enable markets to operate efficiently (Gradl et al., 2008; Mendoza and Thelen, 2008).

BoP market participants generally lack access to labour markets, relevant market information and diverse financial services. For example, many producers in BoP markets do not live in close proximity to large domestic markets or transportation hubs for domestic and foreign export markets. As a result, the producers may participate at a significant disadvantage compared to more productive labour markets, or they may even be excluded from participating in labour markets depending on their geographic location (Gradl et al., 2008).

Further, the BoP market is often a dark area as a result of the paucity of information available. Therefore, basic information such as population data within a particular geographic area may not be available to producers, and the data that is available may be skewed due to the lack of record of births, deaths or movement of people. Other information such as consumer behaviour, spending patterns or consumer preferences simply may not exist. What little market data that is available may not be accessible due to the absence of intermediaries such as market research firms (Gradl et al., 2008).

The lack of access to finance products and services such as bank accounts, credit and insurance is a major barrier restricting market participation of both producers and consumers. Without access to basic banking services such as savings and checking accounts, managing financial resources and conducting business transactions is less efficient and often more costly. Access to credit and insurance products is crucial for capitalising on opportunities and reducing vulnerability to significant exogenous shocks. For instance, producers can leverage credit to finance investments needed to improve and scale their business, and consumers rely on credit to acquire larger retail purchases (Gradl et al., 2008; Mendoza and Thelen, 2008).

Insurance products can help producers improve creditworthiness and increase propensity to invest by reducing risk exposure to calamities such as premature death, injury or natural disasters. Producers that are members of farming cooperatives can leverage insurance mechanisms to reduce exposure to price volatility of agricultural commodities. However, poor producers in BoP markets have limited access to insurance coverage because insurance penetration in developing countries (4%) is much lower compared to industrial markets (9%). In fact, the lack of access to financial services has commonly been cited as a significant underlying factor that limits the potential of producers and consumers in the market economy (Gradl et al., 2008; Mendoza and Thelen, 2008; Yunus, 1999; Yunus and Weber, 2010).

Infrastructure barriers can simultaneously reduce efficiency while increasing the cost of transacting business in BoP markets. For example, transportation systems, utilities and data networks tend to be deficient in rural areas and urban slums. This may result in lost productivity due to lack of access to technology and logistical log jams. Basic physical infrastructure, such as roads and utilities, may be nonexistent in remote areas, which severely limits business investment and expansion in those regions. Therefore, infrastructure fulfills a critical underlying role in how BoP markets function. As a result, infrastructure barriers present not only obstacles for market interaction between producers and consumers, but also impact operational efficiency and growth potential of businesses participating in this market (Gradl et al., 2008; Mendoza and Thelen, 2008).

The lack of skills and capabilities is a prevalent problem for both producers and consumers participating in BoP markets. Low levels of literacy and education are two primary factors constraining skills and capabilities among BoP market participants. As mentioned previously, low literacy is one of the most significant impediments impacting virtually all interactions within the BoP market. As a result, consumers may lack the

ability to read important product related information that might influence the purchase a particular product. Low literate producers may be unfamiliar with new technologies or financial services, which often reduces utilisation of these important business related products and services. Education is often closely linked with the development of skills and capabilities, and people in developing countries tend to receive fewer years of education compared to those in advanced countries (Barrow and Lee, 2010; Gradl et al., 2008; Mendoza and Thelen, 2008).

Government poses a final barrier that constrains business activity in the BoP market. Political corruption and burdensome government regulation are endemic, which can drastically increase the cost of doing business. Further, the lack of property rights and legally enforceable business contracts is common in BoP markets. Therefore, legally transacting business in the formal economy tends to be expensive for BoP market participants. Governments also often intervene in BoP markets through state-directed or subsidised credit. Subsidies may be targeted at various industries such as lending and credit in an attempt to keep interest rates low for poor borrowers. However, subsidies often end up in the hands of the wealthy or those who are politically well connected, and the infusion of government money often undercuts local BoP producers who were providing financial services before the intervention. As a result, the intervention may undermine the quality and extent of services provided within the BoP market, and BoP market participants are often worse off after government intervention in the market (Armendariz de Aghion and Morduch, 2005; De Soto, 2000; Gradl et al., 2008; Mendoza and Thelen, 2008).

The various barriers discussed above present ongoing challenges for market participants transacting business in the BoP market. Although local market participants are familiar with the unique context and associated barriers that characterise the BoP market, MNCs are not as accustomed to conducting business in this environment. MNCs have not traditionally targeted BoP markets. However, firms are beginning to recognise the potential of developing these untapped markets. For MNCs, targeting BoP markets presents a new global opportunity beyond traditional approaches to seeking new markets in emerging countries. Therefore, it is important to explore how MNCs may develop global strategy (the BoP approach) to successfully target and penetrate BoP markets.

2.1.3 BoP Approach

As growth rates have slowed in developed markets in Europe and North America, MNCs have increasingly turned to emerging markets (EMs) in developing countries such as China, India, Brazil and Russia. In doing so, they have typically focused on the wealthy at the top of the economic pyramid and the rising middle class rather than the BoP market (London and Hart, 2004; Prahalad and Lieberthal, 1998). MNCs have relied primarily upon the transnational approach when developing global strategy to reach these top and middle of the pyramid markets (Tallman, 2001). This approach is based upon organisational capabilities such as global efficiency, national responsiveness and worldwide learning (Bartlett and Ghoshal, 1989). However, to reach the BoP market, London and Hart (2004) suggest that the transnational approach is inadequate and that a new capability and innovative strategies are needed to penetrate this market.

2.1.3.1 Beyond the Transnational Model

Three central capabilities comprise the transnational model, or transnational approach to global strategy, and firms following this approach must simultaneously develop these capabilities. First, transnational firms must seek global efficiency by centralising control and decision-making and leveraging economies of scale and scope. By centralising its resources and capabilities, the transnational firm can achieve efficiency through exploiting economies of scale in all its activities. Developing world-scale economies allows transnational firms to lower costs, and centralisation of knowledge and skills leads to greater efficiency in managing innovations. As a result, the firm can ultimately develop new products and processes quickly and at a relatively low cost (Bartlett and Ghoshal, 1989).

Although centralisation is integral for efficiency, resources and capabilities are not necessarily centralised in the firm's home market. For example, world-scale manufacturing plants may be located in a low-wage country such as Singapore, and more advanced technological processes may be centralised in Japan or Germany. Such flexible centralisation augments the benefits of economies of scale by providing access to the best resources and capabilities, which may be located across country borders. In addition, the transnational firm's resources and capabilities that drive global efficiency are integrated through strong interdependencies. The world-scale manufacturing plant in Singapore may depend on a world-scale component plant in Germany, and global sales subsidiaries may depend on Singapore for finished products. Therefore, the distribution

of the transnational firm's resources is best described as an integrated network (Bartlett and Ghoshal, 1989).

Second, the transnational model requires that firms develop national responsiveness. This capability allows transnational firms to be sensitive to local needs and opportunities across the various global markets in which they compete. However, the need for responsiveness is complex. For example, customers from different markets around the world demand differentiated products that are equal in quality and price to global products. Frequent changes in economic, social, technological and political environments further complicate organisational ability to successfully develop national responsiveness. It is insufficient for firms to be responsive at a single point in time. Rather, companies must develop the organisational capability in order to remain responsive as consumer tastes change, technologies evolve, regulations increase and exchange rates fluctuate. Flexibility across the value chain is therefore important, and it is central to overall strategy (Bartlett and Ghoshal, 1989).

There are many ways an organisation may build flexibility. For instance, transnational firms plan for excess capacity in manufacturing plants, and adopt flexible automation to handle fluctuations in supply and demand. Further, they may design products with a modular format so that basic components and functions are standardised whereas other features and styles can be differentiated to appeal to specific markets. However, the transnational firm recognises that differentiation is not essential in all markets and appropriately adjusts the roles of its various national operations. As a result, some national subsidiaries operate relatively autonomously and are encouraged by headquarters to differentiate while others implement centralised decisions and adopt standardised global products. Therefore, various subsidiaries assume different roles within the transnational firm. Some may be strategically located or resource rich and play a global role within the firm while others may be given a more autonomous role. Transnational firms appropriately determine the roles of their subsidiaries in order to effectively develop national responsiveness (Bartlett and Ghoshal, 1989).

Finally, the transnational firm leverages worldwide learning to develop creative solutions and diffuse innovations worldwide. These firms simultaneously transfer specialised knowledge throughout the organisation and connect critical resources and capabilities across country borders. Worldwide learning benefits companies beyond merely identifying opportunities across different markets. Instead, the capability enables firms to obtain valuable market data and competitive intelligence and access scarce knowledge and expertise that may not be available in their home market. Thus, global

subsidiaries provide the transnational firm with important information and innovative ideas that can be managed and shared globally (Bartlett and Ghoshal, 1989).

Transnational firms further recognise that market demands and opportunities vary widely across countries and that different areas within the organisation possess different capabilities. Therefore, knowledge is jointly developed within the transnational firm so that innovative products and services can be shared on a worldwide basis. These transnational innovations are locally leveraged and globally linked, and the firm leverages the resources and capabilities of its subsidiaries to create and jointly implement innovations globally. Consequently, to capitalise on worldwide learning, the transnational company combines the resources and capabilities of its central national headquarters with its globally dispersed subsidiaries in order to develop innovative solutions. The innovative products and processes are then diffused globally throughout the entire corporation. Thus, organisational learning is shared on a worldwide basis (Bartlett and Ghoshal, 1989).

It is the simultaneous pursuit of global efficiency, national responsiveness and worldwide learning that characterises the transnational approach to global strategy. The BoP approach, on the other hand, may require a capability beyond global efficiency developed through centralised control, the adaptive skills of national responsiveness or the sharing and diffusion of knowledge through worldwide learning. In fact, London and Hart (2004) found that the capabilities comprising the transnational approach were not only insufficient for MNCs targeting BoP markets, but may even constrain their efforts.

For example, whereas the transnational approach focuses on flexible centralisation and national responsiveness, a decentralised, smaller-scale approach may be more appropriate for BoP markets. Leveraging global efficiency and sharing existing knowledge on a worldwide basis can prevent success in BoP markets because deep listening and local knowledge generation are needed to succeed in these markets. Therefore, the BoP approach tends to require more of a bottom-up solution rather than a standardised global solution or even a local adaptation of a centrally developed solution (Christensen et al., 2001; London and Hart, 2004).

Further, the BoP approach does not rely upon worldwide sharing of products and processes or knowledge transfer through diffusing or adapting existing business models across the entire organisation. Firms targeting BoP markets cannot simply import the same business model from middle or top of the pyramid markets. Additionally, national responsiveness may also prevent success in BoP markets, particularly where existing

solutions and business models are not adequate for the BoP market. Because transnational capabilities alone are insufficient for penetrating BoP markets, a new global capability is needed. This new capability is called social embeddedness, or native capability (Hart and London, 2005; London and Hart, 2004; Prahalad and Lieberthal, 1998).

2.1.3.2 Native Capability

Native capability is central to the BoP approach to global strategy. It enables an organisation to build a web of trusted connections with a wide range of local market participants and become embedded within the local BoP market context. As a result, native capability allows the organisation to gain deep understanding of the local environment, build on the local social infrastructure and generate bottom-up solutions. Local market participants view the organisation as a natural part of the local landscape instead of a foreign or alien force that does not fit within the local market context. Because embeddedness within this local environment takes time to develop, it is difficult for competitors to imitate. Thus, the deep understanding and integration within the local market can be a source of competitive advantage for the firm that develops native capability (Hart and London, 2005; London and Hart, 2004).

Further, organisations that develop native capability are able to craft strategies based upon the knowledge and resources that exist in the external environment. This approach challenges and extends the conventional transnational model, which is a more top-down, internally focused approach that leverages and transfers knowledge and resources within firm boundaries. Whereas the transnational approach focuses on transferring proprietary resources within the firm, the BoP approach is dependent upon accessing knowledge and resources beyond firm boundaries. Therefore, competitive advantage is founded more on developing trust and social capital instead of protecting existing patents or proprietary technology (Hart and London, 2005; London and Hart, 2004).

For firms to develop this new capability, they must implement strategies that leverage the inherent strengths of the local market context. These strategies include collaborating with non-traditional partners, co-inventing custom solutions, building local capacity, avoiding dependence upon central institutions, and creating social, not legal, contracts. Consequently, implementing the strategies enables firms to develop contextualised solutions to common problems that respect the culture and diversity of the local market context. These strategies are essential for developing native capability

and allow firms to become indigenous to the locations in which they compete (Hart and London, 2005; London and Hart, 2004).

First, to develop native capability, firms must collaborate with non-traditional partners. It is common for firms to seek traditional corporate partners to fill expertise and resource gaps when encountering new challenging environments (Eisenhardt and Schoonhoven, 1996). Further, governments often require that multinational corporations engage a local corporate partner to ensure access in emerging economies (Blodgett, 1991). However, when targeting the BoP market, firms may need to expand their scope of alliance partners. London and Hart (2004) found companies that successfully serve the BoP market significantly rely upon non-traditional partners such as non-profit organisations, community groups and even local and village-level governments. Successful companies did not rely on traditional partners such as governments or large corporations because they did not have pertinent business knowledge of the BoP market in their own country. The non-traditional partners, on the other hand, were able to provide crucial information regarding the BoP market context such as the general business environment and target customers.

Hart and Sharma (2004) suggest that working with non-traditional partners enables firms to develop radical transactiveness (RT). RT is the ability to engage non-traditional partners, or fringe stakeholders, in a two-way dialogue to continuously acquire and combine knowledge for the purpose of managing disruptive change and creating competitive imagination. In BoP markets, fringe stakeholders often hold knowledge and perspectives that are important for identifying both potential problems and innovative opportunities. By integrating the voices and concerns of non-traditional partners, RT enables firms to deepen relationships and develop goodwill with diverse stakeholders.

Although non-traditional partnerships are important for success in BoP markets, they can be difficult to manage. For example, while corporations and socially oriented organisations have begun to collaborate more frequently, tensions often arise in non-profit-corporate alliances due to underlying differences in goals and orientations. Therefore, collaboration with non-traditional partners requires careful design and ongoing attention to effectively share knowledge and maximise impact (Brugmann and Prahalad, 2007; London and Rondinelli, 2003).

Second, firms must co-invent, or co-create, custom solutions in order to develop native capability. Prahalad and Ramaswamy (2002) suggest there are four building blocks for co-creating value, including dialogue, access, risk reduction and

transparency. These building blocks allow firms to understand unique social and culture contexts, broaden their view of business opportunities, reduce risk exposure and increase value to customers. Therefore, as firms pursue BoP markets, Prahalad (2010) claims that firms should co-create value in order to gain local knowledge, access context-related skills and resources, reduce capital requirements, develop trust and become a locally relevant market participant.

Co-creation extends far beyond the transnational concept of national responsiveness, which adapts pre-existing solutions to local conditions. Instead of imposing top-down, pre-existing solutions, the BoP approach stresses leveraging local partnerships to co-create every aspect of the product or service. Therefore, local partners contribute information and input into everything from product design to pricing to distribution. As a result, firms tend to allow the product and business model to coevolve. Successful ventures often allow everyone involved in the co-creation process to make money, and these initiatives ultimately become embedded in the local market through developing a product or service that is relevant to local customers (Hart and London, 2005; London and Hart, 2004).

Third, developing native capability requires that companies build local capacity. Whereas the transnational approach focuses on sharing resources internally, native capability requires local capacity building through sharing resources outside firm boundaries. Thus, the BoP approach considers economic as well as social performance. Firms can pursue this dual focus by integrating local capacity building directly into the business model rather than through traditional corporate philanthropy. For example, capacity building can include training programmes for BoP entrepreneurs, providing opportunities for existing institutions such as local microfinance organisations and filling gaps in local infrastructure through providing basic services. A firm could also create strategic bridges between diverse stakeholders, which may be struggling to cooperate due to mistrust, tradition, logistical problems, power imbalance or lack of resources and expertise. The strategic bridge may allow the firm to further its own interests while simultaneously serving the interests of other stakeholders (London and Hart, 2004; Sharma et al., 1994; Westley and Vredenburg, 1991).

Fourth, firms must eschew dependence upon central institutions to develop native capability. These institutions include national governments, corrupt regimes and central infrastructure planning. By avoiding dependence upon these institutions, firms can fly under the radar by circumventing common problems such as instability, corruption and bureaucracy. Firms that design large-scale products that offer

nationwide, centralised solutions to address problems such as energy or clean water often target large institutions in developing countries. However, dependence upon unstable and corrupt governments can be detrimental to the company, especially where politicians or officials may benefit politically or economically from delaying or even derailing a venture. In some cases, this dependency could put the viability of the company at risk. Launching a business on a smaller-scale, on the other hand, and allowing it to grow unhindered by institutional intervention allows firms to bypass unnecessary complexity and corruption associated with institutional dependency. Therefore, a small-scale venture with a product or service that is directly affordable by the end consumer is less likely to get enmeshed in bureaucracy and corruption (Hart and London, 2005).

Finally, firms should seek to develop social, not legal, contracts when conducting business in BoP markets. As previously discussed, people living in the BoP demographic tend to transact business in the extralegal or shadow economy due to the absence of enforceable contract law and property titles. Extralegal or shadow economies comprise a significant percentage of the overall economy for many developing nations. As a result, social capital is central to how BoP markets operate. BoP markets lack various legal resources, but they are rich in other areas such as interpersonal relationships and local market intelligence (De Soto, 2000; Schneider and Enste, 2000; Schneider et al., 2010; Viswanathan, 2007).

Western-style institutions are typically unavailable in BoP markets, and legally enforceable business contracts are not common. Therefore, firms must leverage the existing social infrastructure when launching ventures in BoP markets instead of attempting to implement Western-style business contracts. For example, the Grameen Bank in Bangladesh pioneered a peer lending model in banking. Since BoP entrepreneurs typically do not have collateral, legal contracts are impractical. Therefore, the peer lending model leverages social capital by lending to small groups of business owners and making the loan recipients mutually responsible for repayment of loans within the group. Borrowers are consequently subject to social, not legal, contracts, and the business model is built upon social capital and trust (Hart and London, 2005).

Because the BoP approach requires the development of a new capability and the implementation of new strategies, entering this new market presents unique challenges for multinational corporations. In particular, it breaches many of the assumptions associated with serving traditional top and middle of the pyramid markets. In order to successfully enter BoP markets, MNCs must shed established mindsets, systems and

metrics. These entrenched corporate paradigms can be extremely difficult to change. Therefore, one of the biggest challenges for MNCs striving to penetrate the BoP market is often that of business model innovation, or business model development (Hart and London, 2005).

2.1.3.3 Business Model Development for BoP Market Entry

As stated above, the BoP approach requires a market entry strategy beyond importing and adapting business models through worldwide learning and sharing knowledge within company borders. Therefore, firms must fundamentally rethink and innovate their business models through engaging in business model development (London, 2010; London and Hart, 2004). The idea of innovating the business model to reach the BoP market is not new. In fact, several authors have repeatedly suggested that business model innovation is essential for doing business in the BoP market and have supported their claims through various case studies (Prahalad, 2006, 2010, 2012; Prahalad and Hammond, 2002; Prahalad and Hart, 2002).

Prahalad (2006, 2012) recommends several conditions for designing innovative business models to reach the BoP market. First, innovation must start with a deep immersion into consumers' lives. Second, it must result in a world-class product or service. Third, it must achieve a significant reduction in price – possibly up to 90% off the cost of comparable Western products and services. Fourth, the innovation must be scalable so that it can be produced, marketed and used in many diverse contexts. Fifth, innovation goes beyond merely developing a product; it creates an entire ecosystem enabling a new business to function. Finally, the innovation must focus on the 4As – awareness, access, affordability and availability. This innovation sandbox permits exploration and experimentation within a market context that faces many barriers and fixed constraints, and it enables creation of an ecosystem that is cost-effective, scalable, and provides critical knowledge and skills.

Thus, innovation facilitates the development of new business models that are low price, high-volume, technologically based and mobile-driven. Firms have also innovated their business models by leveraging direct selling to distribute within BoP markets and converting fixed costs to variable costs to increase organisational flexibility. In addition, companies have discovered that the shared access model is effective in BoP markets because the model disaggregates access from ownership by providing services on a pay-per-use basis. The shared access model has enabled

companies to increase revenue per dollar of investment in the underlying asset (Prahalad, 2010; Prahalad and Hammond, 2002).

London (2005, 2009a, 2010) acknowledges the fundamental importance of business model innovation and opens the black box of business model development regarding BoP market entry. From his analysis of 18 MNC initiatives, London identifies several core components that significantly impact business model development and include structure, metrics, boundary-spanning in problem solving and access to financial resources. When the various components are properly aligned, they can generate context-appropriate business models necessary for entering BoP markets.

Structure is the location within the firm in which the initiative is incubated and can provide a barrier that protects it from traditional metrics and processes. Structural protection for initiatives emerged from two sources. Firms often created an entirely new structure in order to protect an initiative from existing metrics and processes. This type of isolated structure provided a buffer, or internal white space, in which to incubate the initiative. Alternatively, firms positioned initiatives in a corporate functional department not required to demonstrate short-term financial returns. Initiatives that were not provided structural protection struggled to escape traditional metrics and processes (London, 2005, 2009a, 2010).

Metrics are the systems of measurements firms used to evaluate venture performance and allocate resources. Companies typically prioritise resource allocation based upon short-term financial metrics. BoP initiatives often do not perform well financially on a short-term basis. Therefore, initiatives that were originally targeted at BoP markets transitioned to middle-of-the-pyramid markets due to short-term metrics. Initiatives that were not subjected to the short-term financial metrics successfully remained focused on BoP market entry. These initiatives relied upon long-term learning oriented performance metrics (London, 2005, 2009a, 2010).

The team managing the initiative could integrate relatively high or low levels of internal and external diversity regarding its problem-solving approach, and measurement of the diversity was based upon boundary-spanning. Internal diversity was measured by the extent to which the initiative relied upon individuals from other areas within the company. External diversity was evaluated by the involvement of participants from external partners. Where boundary-spanning was low, initiatives relied upon familiar problem-solving approaches such as replicating business models. Conversely, when boundary-spanning was high, the initiative had the ability to develop new approaches and business models (London, 2005, 2009a, 2010).

Access to financial resources also played a role regarding business model development. The initiatives had access to two primary sources of financial capital. The first was financial capital from the firm's ongoing operating budget tied to short-term financial performance. The second source was patient capital, which is capital that allows for a longer time horizon regarding financial returns. The source of patient capital included grants from internal and external sources, and initiatives that attracted patient capital engaged in new business model development (London, 2005, 2009a, 2010).

Two types of initiatives emerged which were either component-oriented or architecture-oriented. Component-oriented initiatives developed strong relationships with external partners and attempted little internal boundary-spanning. These initiatives were designed to facilitate learning about the business model but were not expected to generate financial returns. Architecture-oriented initiatives tested the full business model by developing boundary-spanning relationships with internal and external partners, which resulted in new problem solving approaches and internal support for the new initiative. Therefore, to enter new markets and pursue business model development, firms should recognise the difference between component-oriented and architecture-oriented approaches to business model development (London, 2005, 2009a, 2010).

Overall, the initiatives that maintained focus on entry into BoP markets properly aligned structure, metrics, boundary-spanning in problem solving and access to financial resources in order to effectively engage in business model development. For example, several initiatives transitioned to middle-of-the-pyramid markets due to influence from existing company metrics and problem-solving approaches. Although the BoP market was targeted, actual market entry was altered due to traditional metrics and approaches. The initiatives that maintained focus on BoP market entry needed diversity in their problem-solving approaches and long-term learning oriented metrics. Thus, differences between the logic of replication (middle-of-the-pyramid market entry) and the logic of R&D (BoP market entry) highlight the importance of properly aligning the core components of business model development (London, 2005, 2009a, 2010).

Business model development for market entry is critical because the BoP market represents a substantial latent market for many goods and services. The poor often do not have access or experience using many products and services, and as a result, the BoP market represents a significant untapped opportunity for value creation (Prahalad, 2010). Therefore, organisations should be more open-ended in their marketing strategy when developing BoP ventures because consumers may not be familiar with new

products and services or have a reference point for assessing value (Simanis, 2009). This means marketing plays an important role beyond business model development for initial market entry, and the literature provides several key insights for targeting and engaging the BoP market.

2.1.3.4 Marketing Insights for Targeting the BoP Market

Because the BoP market represents a latent market, market creation is a crucial first step in the marketing process and vital to the success of any BoP venture. A venture development protocol has been developed to address this issue (Simanis, 2010; Simanis et al., 2008). The protocol sets forth a comprehensive methodology that helps ensure BoP actors coevolve a new venture and a new market simultaneously through an embedded innovation process (Simanis and Hart, 2009). The BoP protocol is illustrated in the following figure.



Figure 2.2: BoP Protocol (SOURCE: Simanis and Hart, 2009)

The protocol is valuable for companies because many of the products firms have marketed to BoP markets are not things that BoP consumers would normally buy. These consumers have not adapted their behaviours and budgets to fit the new products into their lives. Therefore, companies must create markets, and new lifestyles, in order to effectively target the BoP market. Instead of following a more conventional approach to entering a new market, which includes traditional marketing research and test marketing, companies should immediately get the community involved in creating, implementing and shaping the entire business from the beginning (Simanis, 2009).

Companies can accomplish this by implementing the BoP protocol, which includes three interdependent phases. Phase I is called Opening Up and begins with

home stays and deep dialogue within the community in order to build rapport and trust. This helps overcome skepticism and cultural distance between the organisation and community. The outcome of Phase I is co-creation of a business concept with a core team of community partners. Phase II is called Building the Ecosystem and forms the organisational foundation for the new business with core partners and creates an initial brand and product/service offering through an action-learning process that engages the broader community. Phase III is called Enterprise Creation and establishes a committed market base by reaching out to an even broader segment of the community through action learning and small-scale tests. Sufficient local management capacity must be developed to manage and grow the business. The result is a locally embedded business and committed local market (Simanis and Hart, 2009; Simanis et al., 2008).

When establishing a new market, firms must consider the BoP market context. As discussed earlier, Ritchie and Sridharan (2007) evaluate how producers and consumers in BoP markets leverage social relationships to create social capital, and they argue that social capital is central to how BoP markets operate. Therefore, in order to leverage social capital, they argue that marketing activities should be decentralised and externalised to utilise available social capital. Decentralising marketing means shifting product, pricing, distribution and promotional activities further down the value chain in order to improve responsiveness to customer needs and feedback. Thus, tapping into social capital is crucial in BoP markets where local participants hold vital market intelligence such as knowledge of buyer needs, wants and ability to pay.

Externalising marketing means appropriately assigning marketing roles and functions outside of the firm. This often results in forming partnerships with local market participants and allowing partners to execute marketing decisions instead of hiring employees and internalising marketing activities. Externalising marketing is attractive because social capital is most effectively utilised across a broad range of relationships within the market. Externalising and decentralising marketing are important considerations for a firm targeting BoP markets for several reasons. First, an externalised/decentralised marketing approach may increase efficiency and effectiveness. Efficiency gains can be realised by maximising social capital, which may reduce transaction costs by eliminating the need for contracts or improving contractual terms. Second, an externalised/decentralised approach is adaptable because it relies on a network of partners that are well informed of local market conditions. Finally, shifting marketing activities to local participants enhances their wealth and ultimate attractiveness as a market (Fukuyama, 2001; Ritchie and Sridharan, 2007).

Sridharan and Viswanathan (2008) provide further marketing insights based on the BoP market context in South India. From their understanding of buyer, seller and marketplace behaviours (low literacy, uncertainty and lack of control, one-on-one interactions, social capital, etc.), they specify three marketing principles for targeting the BoP market. The principles include deep understanding of consumer psychology, social embeddedness and entrepreneurial empowerment. Understanding consumer psychology is important because low literate consumers may not understand how or why they should use products. Therefore, a company that understands consumer psychology may combine a promotional campaign with an educational campaign to educate and persuade consumers to use a product as simple as soap that helps kill bacteria and prevent disease.

Socially embedding an initiative in a community is important for venture success and requires building on the local market environment. Companies can accomplish this by working with local communities, building relationships and leveraging available human capital. For example, by working with local self-help groups that function on the basis of personal relationships, firms can build upon the 1-1 interactional market context. Companies can further socially embed initiatives within local communities by recruiting from the local workforce or aligning products and services with existing socio-cultural traditions. In addition, firms should empower their suppliers, and even employees, as entrepreneurs. For example, a company can source products from local self-help groups or allow employees to act as owners who operate their own businesses within the company (Sridharan and Viswanathan, 2008).

Insights from the three principles – deep understanding of consumer psychology, social embeddedness and entrepreneurial empowerment – have a number of implications for marketing practise. Therefore, using the 4As marketing framework (acceptability, affordability, availability and awareness), Sridharan and Viswanathan (2008) build upon the three principles and discuss five essential marketing strategies for targeting BoP markets. The marketing strategies include marketplace research, development of marketplace solutions for the poor, establishing partnerships to co-create value, designing value propositions based on affordability and tradeoffs and engaging in communications and interactions through social networks.

To effectively target the BoP market, firms must conduct market research. Understanding consumer psychology plays an important role in this type of research because it accounts for unique factors such as low literacy and socio-cultural context. Thus, it facilitates relevant and effective market research. Because local consumers and

producers in BoP markets typically lack experience in marketing research, realistic product testing is preferred over abstract tasks. Product testing should represent the actual product as much as possible because low literate consumers often focus on experiential attributes. The length of procedures should be reasonable and tasks should be familiar to participants. In addition, conducting marketing research and collecting data in person can build rapport and trust within the community. The BoP market thrives on social capital and functions as an interdependent network. Therefore, firms should study collective groups within communities and rely on group research methods such as focus groups. Finally, examining word of mouth and views of local leaders is important because leaders influence opinions within the community (Chikweche and Fletcher, 2010; Sridharan and Viswanathan, 2008; Viswanathan et al., 2008b).

Developing marketplace solutions for BoP markets entails developing solutions that solve problems rather than merely selling products. BoP consumers face scarce resources so solutions need to be developed that meet basic needs. Effective marketplace solutions can have a significant positive impact upon people's lives. For example, cell phones meet critical communication needs and nutritional supplements prevent life-threatening diseases. Because contextualised solutions are needed to address poverty-related problems, a traditional product development approach may not work well. Rather, a field-based, collaborative approach is needed. Partnerships are critical for sharing knowledge, learning and co-creating innovative marketplace solutions. As the scope of partners expands, large networks can form. Collaboration with a wide variety of partners provides firms access to input and feedback from market participants, and it facilitates co-creation of innovative solutions that benefit BoP market participants (Sridharan and Viswanathan, 2008).

Value propositions must be appropriately developed for BoP consumers to buy into innovative marketplace solutions. Due to resource constraints, only a narrow price range is tenable for BoP consumers. However, BoP consumers are willing to pay higher prices for certain products, such as cell phones, that provide significant value. Therefore, firms targeting BoP markets should emphasise value over price and carefully communicate long-term benefits that outweigh immediate cost (Sridharan and Viswanathan, 2008).

Communication is also important because BoP markets impose informational constraints resulting from low literacy and lack of access to certain forms of mass media. As a result, marketing communication should be developed from the ground up. Village fairs, vehicle advertisements and other local forms of media are useful. Further,

the BoP market context tends to exhibit a socially oriented, 1-1 interactional nature. Spokespersons or sales people can be hired in local BoP markets as brand communicators that create interactions with consumers instead of other standardised, unidirectional forms of communication. In addition, oral communication is vital in low literate environments. Therefore, effective marketing communication leverages social networks and widespread oral communication to influence word of mouth and information sharing in BoP markets (Sridharan and Viswanathan, 2008; Viswanathan et al., 2008b).

Similarly, from their research of multiple case studies, Weidner et al. (2010) suggest a broad range of marketing best practises of commercial and social enterprises serving the BoP market. The best practises describe how organisations have successfully marketed to BoP markets, and the entire process is illustrated in the following figure.

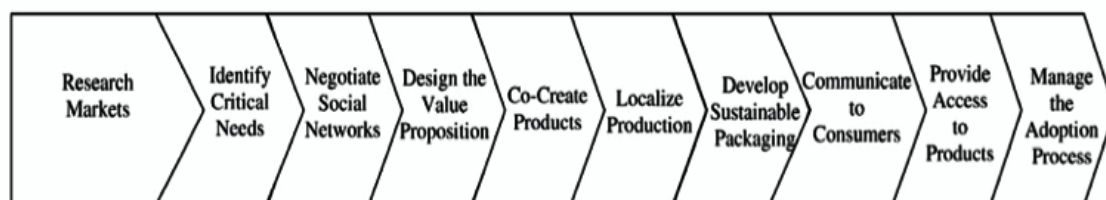


Figure 2.3: Marketing Process (SOURCE: Weidner et al., 2010)

Some of the best practises overlap with Sridharan and Viswanathan's (2008) marketing strategies such as researching markets, negotiating social networks, designing the value proposition, co-creating products and communicating to consumers. However, the best practises established by Weidner et al. (2010) suggest a more comprehensive approach and provide a direct line of sight through the entire marketing process, which begins with marketing research and ends with adoption.

As discussed earlier, marketing research is essential for effectively targeting BoP markets. One of the most common research methodologies that has been adapted for researching BoP markets is Participatory Rural Appraisal (PRA). PRA comprises various approaches and methods, such as visual mapping, that enable people to analyse and understand their life and conditions, plan and take action. In PRA, the research process is driven by the community because it is assumed that local people are best positioned to identify and analyse their problems. Therefore, the fundamental proposition in PRA is that all community members possess valuable insights and should be included in the research process regardless of position or status (Chambers, 1994, 1997; Ozanne and Saatcioglu, 2007). PRA is an effective research approach in BoP

markets because it enables researchers to engage BoP market participants as valuable sources of information and solutions. Therefore, it is integral that research teams include community members from BoP markets throughout the marketing research process (Sridharan and Viswanathan, 2008; Viswanathan et al., 2008b; Weidner et al., 2010).

Researching BoP markets leads to the identification of problems and critical needs. In BoP markets, basic needs often go unmet due to adverse living conditions and resource constraints. Therefore, deep understanding of BoP markets is essential for identifying basic needs in areas such as communication or health care. Needs must be identified in order to develop products and services that are relevant for BoP markets. Further, once products and services are created, firms must negotiate social networks because social capital is central to how BoP markets operate. Because of the highly interactional nature of the BoP market, firms must leverage social capital and social networks. This means that companies may reach out to BoP consumers through direct selling techniques or work with community groups to empower BoP entrepreneurs (Weidner et al., 2010).

Although BoP consumers face resource constraints, they often do not want low quality products. Therefore, value propositions must be created carefully with both cost and quality in mind. Lowering cost yet maintaining an acceptable level of quality requires innovation. Organisations should challenge conventional industry wisdom and can innovate in areas such as product design, packaging size and distribution method. Firms can further lower costs by reducing the ratio of fixed to variable cost and deskilling production and distribution processes. Community participation and input should also be considered during the creation of the value proposition in order for firms to successfully co-create products and services. Co-creation requires that community members are involved in all aspects of the development process including research, design and production. Therefore, BoP market participants should determine how products are used and how their value is defined (Prahalad, 2006, 2010; Weidner et al., 2010).

Localising production is another marketing best practise that is essential for successfully targeting BoP markets. For example, organisations can simultaneously empower BoP market participants to establish local designs and production parameters as well as source locally available and renewable resources. Empowering locals and leveraging local resources has many benefits. First, local empowerment and resource utilisation can result in higher adoption rates for products and services. Second,

localising production provides economic opportunities for local community members. Finally, a localised approach is sustainable (Weidner et al., 2010).

In particular, sustainability is critical in BoP markets because industrial development, while beneficial economically, has produced numerous negative impacts on the environment. Organisations can practise sustainable marketing by hiring local labour and seeking locally produced, environmentally sound raw materials. In addition, firms can use recyclable or biodegradable materials in their product packaging. Sustainable packaging requires innovation and can enhance product safety and freshness, which may improve brand consistency and image. As a result, sustainable marketing practises can simultaneously deliver economic, social and environmental benefits (Hart, 2005a; Hart and Milstein, 2003; Weidner et al., 2010).

As discussed earlier, organisations should carefully choose how they communicate to BoP consumers. Tactics such as brand name selection, demonstrations and word of mouth are all commonly used approaches in BoP markets. In particular, branding can generate positive associations with products and services, and linking the brand to values can engender a sense of community. When brands symbolise cherished community values, solidarity networks often develop and communication may spread rapidly by word of mouth with little formal promotion. Further, appropriate communication is important in BoP markets because low literate consumers typically resist the more common forms of communication and promotions used in developed markets (Weidner et al., 2010). Traditional promotions such as discounts and coupons are often confusing for low literate BoP consumers and even may cause them to switch away from promoted brands. When encountering such promotions, BoP consumers often lack the ability to evaluate price-discount calculation and anxiety can result in avoidance of promoted products. Further, promotion through mass media channels in BoP markets is usually not as effective compared to social networks (Viswanathan et al., 2005).

Promotional activities are of no use if customers cannot access products and services. BoP consumers have low incomes, so they often rely on local store owners to obtain credit for purchases. Therefore, to improve access to products and services, firms can distribute through local businesses as well as work with the owners to introduce new offerings or extend credit. In BoP markets, consumers and producers may live in remote or isolated rural villages with limited or no access to motorised transportation. Further, developing countries often do not have an accurate census of these remote villages, which complicates enabling access markets in these areas. Therefore, local

residents play an important role in targeting rural areas because they have specific knowledge of the local market such as location and population information. To ensure remote or isolated villages have access to products and services, firms should engage local BoP market participants to gain market knowledge and leverage social networks to improve distribution (Weidner et al., 2010).

Once access has been provided within BoP markets, managing the adoption process is essential because many consumers do not initially adopt products and services. Due to lack of education, limited income and low literacy, BoP consumers may not adopt products until benefits have been clearly demonstrated or validated by other members of their community. There are many tactics that organisations can leverage to manage the adoption process including understanding sources of resistance, identifying and empowering opinion leaders, encouraging positive word of mouth from satisfied customers and respecting village norms and social networks. Solutions should be designed around communal interdependence, and a broad range of possible influencers should be engaged such as retail store owners, self-help groups, employees and children. It is important that organisations quickly establish credibility with consumers and properly align incentives among all stakeholders (Weidner et al., 2010).

In summary, the BoP approach requires that firms move beyond the transnational model by developing native capability. This new approach to global strategy requires a market entry strategy beyond importing and adapting business models through worldwide learning and sharing knowledge within company borders. To successfully enter BoP markets, firms must fundamentally rethink and innovate their business models through engaging in business model development. Business model development for market entry is critical because the BoP market represents a substantial latent market for many goods and services. Consequently, marketing plays a crucial role when targeting and engaging BoP markets, and penetrating BoP markets provides new potential business opportunities that can increase profits. Karnani (2006, 2007), however, cautions that targeting BoP markets can result in exploitation of the poor. Therefore, organisations that target BoP markets must focus on poverty alleviation as well as profits (London et al., 2010).

2.1.4 BoP Perspective

The BoP perspective is a new and unique perspective on poverty alleviation, and the simultaneous pursuit of profits and poverty alleviation is the hallmark of this perspective. Whereas some believe development and aid are the answers to ending

world poverty (Sachs, 2005), others claim that the hope of earning profits from BoP markets is merely a mirage and that attempts to earn profits will not benefit the poor (Karnani, 2006, 2007). BoP researchers, on the other hand, have continually emphasised that organisations can simultaneously earn profits and alleviate poverty (London, 2007 (July); London and Hart, 2004; London et al., 2010; Prahalad, 2004, 2010; Prahalad and Hammond, 2002; Prahalad and Hart, 2002). Prahalad and Hart (2002) call this dual focus on global business strategy and poverty alleviation inclusive capitalism, and London et al. (2010) argues that this dual focus, or mutual value creation, is crucial to successfully penetrating BoP markets.

As a new perspective on poverty alleviation, it is important to understand how the BoP perspective is unique. Prahalad and Hart (2002) explain that developing new products and services for the BoP market requires radical innovation, which is likely to result in improving the overall standard of living of those living in the BoP demographic. This innovation is likely to not only improve their standard of living, but may also lower costs faced by poor consumers (Prahalad, 2006; Prahalad and Hammond, 2002). Therefore, Prahalad (2010) contends that this perspective is unique for two reasons. First, it views the poor living in the BoP demographic as value conscious consumers rather than victims or burdens to society. Second, the BoP perspective proposes that meeting the unmet needs of the poor is a market opportunity that can be served by private enterprise rather than merely a social responsibility that should be addressed through traditional development methods.

Further, London (2007 (July), 2008) identifies six principles that, when combined, distinguish the BoP perspective from traditional approaches to poverty alleviation. Traditional approaches to poverty alleviation can include Western development aid from entities such as the World Bank, the United Nations or USAID and philanthropic charity given through organisations like the Bill & Melinda Gates Foundation and other non-profit organisations (Chambers, 1997; Easterly, 2006; Kandachar and Halme, 2008). Certain traditional approaches may even be market-oriented such as social enterprises, or ventures, and microfinance (Dart, 2004; Haugh, 2007; Yunus and Weber, 2010). London (2007 (July)) explains that the six principles regarding the BoP perspective coincide with the development of a BoP venture and include design, implementation, performance and view of the business environment. The first two principles relate to design; the second two principles pertain to implementation; and the fifth and six principles address performance and view of the business environment, respectively.

2.1.4.1 Design

First, whereas most traditional approaches to poverty alleviation focus on supporting entrepreneurs or businesses developed by those living in the BoP demographic, the BoP perspective involves external entrepreneurs or organisations entering BoP markets (London, 2007 (July), 2008). There are a wide variety of external organisations actively launching ventures targeting BoP markets including multinational corporations (MNCs), small and medium enterprises (SMEs), non-governmental organisations (NGOs) and other non-profit organisations. For instance, MNCs such as Unilever, Procter & Gamble and General Electric as well as non-profits such as Solar Electric Light Fund, Arvind Eye Care and Honey Care Africa have all launched BoP ventures (Hart and Milstein, 2003; Immelt et al., 2009; London and Hart, 2004; London et al., 2010; Nova-Hildesley, 2006; Prahalad and Hart, 2002; Rangan et al., 2011; Wheeler et al., 2005).

London (2007 (July), 2008) notes that external participation in BoP markets can even include host-country nationals. BoP markets across and within countries are not homogenous. In fact, BoP markets are extremely diverse in regard to literacy, income, geographic location, cultural practises and religious beliefs. Therefore, organisations or entrepreneurs targeting BoP markets within their home country may even be non-native to local BoP markets. For example, CEMEX is the largest manufacturer of cement in Mexico. The company traditionally served the formal market in Mexico, which is composed of middle and upper income earners. However, as revenues were falling in these wealthier segments in the 1990s, CEMEX began to look at the informal market at the base of the pyramid. Because CEMEX was non-native to the local BoP market in Mexico, the company had to perform in-depth market research to gain a deep understanding of this market. CEMEX ultimately had to create a new programme called Patrimonio Hoy to target the BoP market in Mexico (Hammond et al., 2007; London, 2007 (July), Prahalad, 2010).

Being native in a particular BoP market does not necessarily transfer to another location. Therefore, organisations should not assume that resources, knowledge or business models will transfer across various BoP markets. As discussed earlier, organisations must develop native capability, implement new strategies and engage in business model development in order to successfully penetrate BoP markets. This is important because the principle of external participation requires that firms enter and conduct business within BoP markets. Alternatively, some institutions, such as microfinance or other development organisations, focus on supporting businesses

developed solely by people living in the BoP demographic. For these organisations, the focus is on promoting local business ideas instead of encouraging external participation (Hart and London, 2005; London, 2007 (July), 2008, 2010; London and Hart, 2004).

Second, most traditional approaches, particularly development aid, tend to take a more top-down approach to poverty alleviation (Chambers, 1983, 1997). The BoP perspective, however, builds upon the consumer-centric principle of co-creation, which is a more bottom-up approach. According to this view, the consumer can influence where, when and how value is created, and there are various points of exchange where the organisation and consumer can co-create value. Therefore, co-creation requires that community members are involved in all aspects of the development process from research to adoption. This inclusive participation promotes active input and feedback from community members, and it produces solutions that benefit BoP market participants. Successful co-creation often allows everyone involved in the process to make money, and these initiatives ultimately become embedded in the local market through developing relevant products or services (Hart and London, 2005; London, 2007 (July), 2008; London and Hart, 2004; Prahalad, 2010; Prahalad and Ramaswamy, 2002).

Further, as previously discussed, organisations targeting BoP markets cannot take a top-down approach to new market entry by importing business models from other middle or top of the pyramid markets. Rather, companies must fundamentally rethink and reconfigure their business models and engage in business model innovation, or development. Business model development requires engagement with BoP market participants, and it should result in a world-class product or service at a significant reduction in price. In addition, the business model must be scalable, create an enabling ecosystem and focus on the 4As. Finally, structure, metrics, boundary-spanning in problem solving and access to financial resources must all be properly aligned to generate bottom-up, context-appropriate business models for BoP market entry (Hart, 2005b; Hart and Christensen, 2002; London, 2009a, 2010; London and Hart, 2004; Prahalad and Lieberthal, 1998; Seelos and Mair, 2007).

Although the complexity and variety of business models have increased, organisations' ability to serve customers has become more challenging because consumers are less predictable concerning how they live their lives. As a result, though business models have become increasingly sophisticated, organisations have less knowledge about the consumer. This divergence between increased knowledge of the business model and decreased knowledge of the consumer is called the innovation gap.

The innovation gap is particularly acute concerning organisations engaging BoP markets. This lack of knowledge of the BoP consumer is further exacerbated by the fact that companies tend to rely upon traditional product-focused or culture-focused marketing research in BoP markets (Kumar and Whitney, 2007; Whitney, 2011).

Product-focused research analyses customers' reactions to products through methods such as home visits, focus groups, interviews and surveys. This research leads to specific insights about current offerings that will enable the company to enhance those current products or services. The problem with product-focused research is that it almost never leads to insights that result in significant improvements or breakthrough new products. Companies often turn to culture-focused research because product-focused research does not normally generate big opportunities. Culture-focused research identifies broader forces and demographic trends that reveal patterns of how people live, but data from these broad trends rarely are specific enough to help a development team create or improve an offering. These design problems commonly face organisations as they engage and attempt to design solutions for BoP markets. Therefore, to serve BoP markets, a strategic approach to design is needed, which is more customer-centred and bottom-up than traditional methods (Kumar and Whitney, 2007; Whitney, 2011).

Strategic design has four general stages including understanding the current context, reframing the problem, prototyping options and developing a road map stating the ultimate goal and where to start. Strategic design seeks a broader context than in the normal design process by considering users' activities and desires. Thus, this type of research is activity-focused, and it reframes the problem at a higher level of abstraction by defining the problem as an activity the customer is trying to accomplish. Evaluating activities that surround the product, rather than assessing reactions to the product, can lead to breakthrough ideas that are grounded in how people live their daily lives. Reframing the problem describes what users really need and want and reveals options of what could be created in the form of a prototype. A roadmap is then designed to create the desired user experience along with a realistic and actionable first step that is grounded in customers' daily lives. The result is that the innovation gap is closed, and balanced innovation is achieved through gaining critical missing information on the users (Kumar and Whitney, 2007; Whitney, 2011).

Strategic design generates insights about users, which is central to achieving balanced innovation, by leveraging ethnographic research methods such as video ethnography, self-documentary camera studies, day-in-the-life studies, shadowing and POEMS (people, objects, environments, messages and services). Ethnographic methods

are important in activity-focused research because the researcher must learn about user activities as they happen naturally during daily life. The researcher can either personally take pictures and video in the consumer's environment or provide disposable or digital cameras to consumers to allow them to capture their own daily activities. The result is that customers become an integral part of the design process. Therefore, by taking a customer-centric, strategic approach to design, organisations can co-create products and services that are grounded in the daily lives of BoP consumers while simultaneously developing a new market from the bottom-up (Kumar, 2009; Kumar and Whitney, 2007; Whitney, 2011; Whitney and Kelkar, 2004).

2.1.4.2 Implementation

Third, the BoP perspective involves connecting the local with the nonlocal (London, 2007 (July), 2008). Rangan et al. (2007) illustrate that BoP ventures can either sell non-locally produced goods and services in BoP markets or distribute products in non-local markets that were created by people living in the BoP demographic. Thus, BoP ventures can serve consumers as well as producers. Conversely, traditional development aid or market-oriented poverty alleviation initiatives often facilitate local transactions within BoP markets or purchase through intermediaries that conduct business in BoP markets. In addition, BoP ventures go beyond merely providing employment to people living in the BoP demographic since no locally produced goods or services are transferred from local to nonlocal markets through employment alone. Because traditional approaches to alleviating poverty typically do not connect local markets with nonlocal markets, they stand in contrast to the BoP perspective (London, 2007 (July), 2008).

In order to connect the local with nonlocal, BoP ventures rely heavily upon partnerships and alliances with a diverse range of organisations and community institutions such as national corporations, non-profit organisations, community groups, entrepreneurs and even local and village-level governments. Organisations often simultaneously leverage multiple partnerships across various BoP markets. The partnerships enable BoP ventures to directly engage and interact with consumers and producers in BoP markets. Thus, these relationships are crucial for BoP ventures to effectively provide non-locally produced goods for sale to BoP consumers or connect BoP producers to non-local markets (Brugmann and Prahalad, 2007; Hart and Sharma, 2004; London and Anupindi, 2012; London and Hart, 2004; London and Rondinelli,

2003; Ritchie and Sridharan, 2007; Simanis et al., 2008; Sridharan and Viswanathan, 2008).

Fourth, patient innovation is central to the BoP perspective. BoP ventures must generate revenue for the organisation, which means goods and services cannot not be given away free (London, 2007 (July), 2008). In order to develop profitable BoP ventures, organisations regularly engage in innovation and business model development (Hart, 2005b; Hart and Christensen, 2002; London, 2009a, 2010; London and Hart, 2004; Seelos and Mair, 2007). For example, Prahalad (2010) advocates a comprehensive philosophy of innovation for BoP markets, which incorporates various principles of innovation such as restructuring the price-performance relationship, hybrid technologies, scalability and sustainability. Kennedy and Novogratz (2011) explain additional innovations that are key to successful BoP ventures including building a BoP-centric management team, implementing human-centric design thinking and establishing trust in BoP markets. In fact, Christensen et al. (2001) suggest that disruptive innovation could hold the key for alleviating poverty in poor countries, and that BoP markets are likely to be hotbeds of innovation for developing future disruptive technologies.

Because innovation is critical for success in BoP markets, organisations must engage in business model development. Further, new capabilities are needed to enter new markets. As a result, entering BoP markets requires the development of new capabilities and business models. As discussed earlier, key components that impact an organisation's business model include structure, metrics, problem-solving and access to financial resources. Business model development is essential because firms cannot rely upon importing business models to compete in BoP markets. Therefore, BoP market entry requires properly aligning the four components of business model development and conceptualising business model development as architectural or component R&D (London, 2005, 2009a, 2010; London and Hart, 2004).

Business model R&D typically requires a long-term time orientation. Therefore, patient capital may be needed (Kennedy and Novogratz, 2011; London, 2007 (July), 2008, 2009a). According to Kennedy and Novogratz (2011), patient capital is an investment of money in which returns are expected over longer time periods compared to other investments such as venture capital. However, patient capital is not a grant. It is an investment that seeks to return principal plus interest. The purpose of patient capital is to maximise social impact and accelerate the creation of markets to alleviate poverty. Although patient capital accepts potentially low or no financial returns and longer

payback periods, BoP ventures should eventually progress toward economic sustainability (Kennedy and Novogratz, 2011; London, 2008; Prahalad, 2010). Thus, the principle of patient innovation is a combination of business model R&D and the investment of patient capital.

Traditional development approaches to poverty alleviation, on the other hand, tend to provide standardised aid or development assistance free of charge. There is generally no anticipation of revenue generation or potential return on investment. It is normally expected that funds will be spent according to predetermined deadlines. Development initiatives are typically expected to be operational within approximately a year, and it is not uncommon for a key metric to include speed at which the aid or development funding is spent. Whereas traditional development funding is often governed by this short-term approach, BoP ventures tend to operate within a more incremental, real options investment framework. Consequently, traditional development approaches prohibit the experimentation and flexibility needed to successfully innovate and preclude any serious attempt at business model R&D (Chambers, 1983, 1997; Easterly, 2005, 2006; London, 2007 (July), 2008; Simanis and Hart, 2006).

2.1.4.3 Performance

Fifth, the BoP perspective emphasises pursuing self-financed growth through developing competitive advantage for the organisation. Self-financed growth is essential for BoP ventures to reach profitability and scalability (London, 2007 (July), 2008). Relationships are primarily established through social rather than legal contacts in low-income markets. As a result, competitive advantage in BoP markets is not typically based on protection of intellectual property as it is in developed markets (De Soto, 2000; Hart and London, 2005). Competitive advantage is more commonly created through establishing various types of partnerships and developing native capability (Brugmann and Prahalad, 2007; Hart, 2005b; Hart and London, 2005; Hart and Sharma, 2004; London and Rondinelli, 2003). Thus, competitive advantage is often based on a deep understanding of and integration with the local market context through developing a web of trusted relationships (Hart and London, 2005).

Because competitive advantage is based upon trust and mutually beneficial partnerships within the BoP market, venture success is inextricably tied to social value realised within the community. Consequently, the positive social impacts felt within the community benefit local venture partners such as agents, distributors, producers and consumers. This is the essence of mutual value creation – simultaneously earning profits

and alleviating poverty. Thus, returns to all partners will increase to the extent that the venture meets the needs of the poor. If social value is not sufficiently created within the community, economic returns will suffer and partnerships will likely dissolve. Therefore, to improve the long-term sustainability of BoP ventures through self-financed growth, organisations should seek unique competitive advantage by developing native capability and maximising social value (Hart and London, 2005; London, 2007 (July), 2008).

Conversely, traditional approaches to poverty alleviation tend to focus on raising the overall viability of an entire industry or sector instead of creating competitive advantage for a single organisation. Although the capabilities of all players in an industry are generally enhanced through these traditional approaches, subsequent competitive advantage is not necessarily secured for any single organisation. Therefore, it will normally be more difficult for organisations lacking a unique competitive advantage within the industry or sector to reach economic sustainability (London, 2007 (July), 2008).

2.1.4.4 View of the Business Environment

Finally, traditional approaches to poverty alleviation often rely on creating an enabling business environment through imposing a Western model of capitalism upon low-income markets (London, 2007 (July), 2008). These traditional approaches tend to focus on transitioning business transactions conducted in the extralegal economy into the formal economy (De Soto, 2000). The BoP perspective, on the other hand, concentrates on what is right at the BoP by recognising there is an inherent economic rationale to the extralegal economy, enhancing what already exists in the BoP market (e.g. resources and expertise) and building from the bottom-up. Therefore, focusing on what is right requires that organisations become locally embedded and innovate new business models for the BoP market (Hart and London, 2005; London, 2007 (July), 2008; London and Hart, 2004).

Hart and London (2005) explain that in order for an organisation to become embedded in the local market, it must develop native capability, which leverages the knowledge, resources and social infrastructure currently accessible in the extralegal economy. Instead of attempting to impose Western-style business approaches and transition business activity into the legal economy, native capability builds upon the current extralegal market and approaches venture development from a bottom-up perspective. As a result, native capability enables organisations to develop

contextualised solutions to poverty alleviation that respect local culture and diversity. Therefore, unlike traditional approaches to poverty alleviation, the BoP perspective builds upon and enhances the existing market environment instead of imposing an external model (London, 2007 (July), 2008).

2.1.5 Summarising the Definitions

As the BoP literature has developed, it has evolved into the four areas described above – BoP demographic, BoP market, BoP approach and BoP perspective. As previously discussed, the BoP demographic and BoP market are interrelated. However, the BoP approach and BoP perspective are distinct and individually compared to the transnational approach to global strategy and traditional approaches to poverty alleviation, respectively. Further, the BoP approach and BoP perspective build upon the concepts of the BoP demographic and BoP market.

The BoP demographic has been described primarily by income such that approximately four billion people earn less than \$3,000 (in 2002 PPP) per capita (Hammond et al., 2007; London and Hart, 2011). However, the BoP demographic is also characterised by diverse social characteristics such as significant unmet needs, existence in the informal, or extralegal, economy and subjectivity to the poverty penalty (De Soto, 2000; Hammond et al., 2007; London and Hart, 2011; Prahalad, 2010).

Understanding these social characteristics is critical when targeting diverse BoP markets, which have a global aggregate market potential of five trillion dollars (Hammond et al., 2007; London and Hart, 2011; Prahalad, 2010). The BoP market is attractive in part because it is a latent market that represents a significant untapped business opportunity (Prahalad, 2010). To understand the BoP market, it is necessary for organisations to become socially embedded in the local community, develop partnerships and co-create solutions (Brugmann and Prahalad, 2007; Hart and London, 2005; London and Hart, 2004; London and Rondinelli, 2003; Prahalad and Ramaswamy, 2002).

Concerning the BoP approach to global strategy, London and Hart (2004) have shown that it is distinctive when compared to the widely accepted transnational approach to global strategy. Whereas the transnational approach is based upon organisational capabilities such as worldwide learning, national responsiveness and global efficiency, the BoP approach is based on a different set of capabilities (Bartlett and Ghoshal, 1989; London and Hart, 2004). The transnational approach and BoP approach diverge in three key areas and is illustrated in the following table.

Global Strategy		
Transnational Approach	vs.	BoP Approach
(1a) Adapt current business models		(1b) Innovate new business models
(2a) National responsiveness (adaptation)		(2b) Social embeddedness (deep understanding)
(3a) Centralised control (economies of scale & scope)		(3b) Decentralised control (smaller-scale)

Table 2.1: Comparison of Approaches to Global Strategy (SOURCE: London and Hart, 2004)

Finally, the BoP perspective is identified in the literature as an alternative, market-oriented approach to poverty alleviation. Traditional approaches to poverty alleviation can include Western development aid and philanthropic charity as well as social enterprise or microfinance (Chambers, 1997; Dart, 2004; Kandachar and Halme, 2008; Yunus and Weber, 2010). The BoP perspective is unique because it views the poor living in the BoP demographic as value conscious consumers and holds that meeting their unmet needs is a market opportunity that can be served by private enterprise (Prahalad, 2010). Further, there are six principles that, when combined, distinguish the BoP perspective from traditional approaches to poverty alleviation (London, 2007 (July)). The differences between the BoP perspective and traditional approaches to poverty alleviation are summarised in the following table.

Poverty Alleviation		
Traditional Approaches	vs.	BoP Perspective
(1a) Non-local entity supports local entrepreneurs/ventures in BoP market		(1b) Non-local entity enters & participates in BoP market
(2a) Import models (top-down)		(2b) Co-create models (bottom-up)
(3a) Facilitate local transactions & job creation		(3b) Connect local with the non-local
(4a) Focus on money spent, free assistance & little R&D investment		(4b) Patient innovation
(5a) Improve viability of all industry members		(5b) Develop competitive advantage for the individual organisation
(6a) Enabling business environment (Western model of capitalism)		(6b) What is right at the BoP (inherent rationale to informal economy)

Table 2.2: Comparison of Approaches to Poverty Alleviation (SOURCE: London, 2007 (July))

It is important to clarify the four definitions of BoP for several reasons. First, the separate definitions are not explicitly differentiated in the literature. Second, it

facilitates the development of each of the four distinct areas in the literature. Third, an enhanced understanding of BoP may practically benefit organisations launching BoP ventures. Finally, clarifying the definitions is important for the purpose of the current research study. The current study involves research in a unique context, and clear definitions are needed to reduce ambiguity and facilitate development of the research. In particular, the focus of the research study is a health care venture that serves rural villages in Afghanistan, which is a developing country located in Central Asia. Therefore, assessing segmentation of the BoP market yields insights that are important for establishing context for the research study.

2.2 SEGMENTING THE BOP MARKET

2.2.1 Overview

As previously mentioned, the WRI-IFC study found that there are approximately four billion people living in the BoP demographic that earn less than \$3,000 (in 2002 PPP) per capita, and it estimated the global market potential of the BoP market at five trillion dollars (Hammond et al., 2007). Consequently, one of the most significant contributions of the WRI-IFC study was providing an empirical foundation for both estimating the total population size of the BoP demographic as well as the potential aggregate dollar value of the BoP market.

Before the study was conducted, size of the global BoP demographic and BoP market were commonly debated. For example, Prahalad (2004) claimed that there are four to five billion people in the BoP demographic with a potential aggregate \$13 trillion PPP BoP market while Karnani (2006, 2007) argued there are only 2.7 billion people in the BoP demographic with a potential aggregate \$0.3 trillion PPP BoP market. These are large discrepancies, and there was no firm empirical data to soundly confirm either side.

However, Hammond et al. (2007) were able to essentially put the debate to rest by providing a firm empirical backdrop for these topics through providing a worldwide set of baseline data. This involved conducting a fairly large study based off of household surveys in 110 countries as well as a set of standardised surveys from 36 countries (Hammond et al., 2007). The study not only provided the empirically based aggregate market potential of the BoP market, but it also segmented the BoP market in several ways. It is the most comprehensive study available in the literature for understanding segmentation of the BoP market. Therefore, the current research study relies upon The Next 4 Billion report as the standard for addressing segmentation of the BoP market.

Leading authors agree that the BoP market is not a homogenous mass market and that differences can fluctuate widely among various segments (Hammond et al., 2007; London and Hart, 2011; Prahalad, 2004; Rangan et al., 2011). Therefore, segmentation of the BoP market is an important matter. The primary way the BoP market is segmented in the WRI-IFC study is by income (Hammond et al., 2007). Using income as the focal point, the current research study further examines BoP market segmentation by region, country and sector.

For example, exploring the BoP market in Asia (including the Middle East), Africa, Eastern Europe and Latin America reveals regional differences (Hammond et al., 2007). This is particularly relevant because the research study takes place in Afghanistan, which is part of Asia. However, Asia is a very large region, and BoP markets vary across different countries. Further, no data was available on Afghanistan for the study.

Therefore, it is also necessary to investigate BoP markets within the neighbouring countries of Bangladesh, India, Nepal, Pakistan, Tajikistan and Uzbekistan. These countries are incorporated in the current research study because they are the nations included in the WRI-IFC study that are closest in proximity and culture to Afghanistan (Hammond et al., 2007). Although BoP markets in these countries do not exactly mirror the BoP market in Afghanistan, analysing the BoP market within these nations provides a reasonable picture of what it might look like in Afghanistan.

Finally, the context of the current research study is specifically focused on assessment of a BoP venture in the health sector in Afghanistan. Therefore, it is important to also investigate how the BoP market can be evaluated by sector. The WRI-IFC study provides details concerning several sectors such as food, water, housing, energy and health (Hammond et al., 2007). These sectors range widely in size and composition and help provide a clearer picture of spending patterns within the BoP market.

2.2.1.1 Income Segmentation

Because the BoP market represents a large economic opportunity, organisations targeting it should strive to understand how to more effectively penetrate this market. According to Hammond et al. (2007; pg. 13), *The BOP makes up 72% of the 5,575 million people recorded by available national household surveys worldwide and an overwhelming majority of the population in the developing countries of Africa, Asia, Eastern Europe, and Latin America and the Caribbean—home to nearly all the BOP.* Graphical representation of the percentage represented by the BoP demographic as a share of the total world population available from national household surveys is displayed in the following figure.

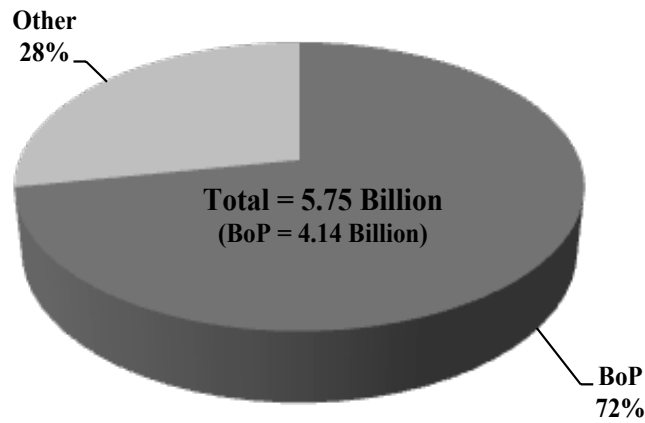


Figure 2.4: BoP Demographic – Share of World Population (SOURCE: Hammond et al., 2007)

Consequently, organisations can better understand the vast five trillion dollar market opportunity by segmenting the market by income. The BoP market can be segmented into six income segments including BOP500, BOP1000, BOP1500, BOP2000, BOP2500 and BOP3000 (Hammond et al., 2007). Characteristics can then be identified within each of the income segments. This segmentation of the global BoP market is illustrated below in Figure 2.4.



Figure 2.5: BoP Market – \$5 Trillion by Income Segment (SOURCE: Hammond et al., 2007)

2.2.1.2 Living Standard Characteristics

One useful way to analyse income segmentation is by living standard characteristics. Rangan et al. (2011) divide the BoP market into three basic income segments – low income, subsistence and extreme poverty. The low income segment includes approximately 1.4 billion people that live on \$3 to \$5 per day; the subsistence segment consists of roughly 1.6 billion people that live on \$1 to \$3 per day; and the extreme poverty segment includes about one billion people that live on less than \$1 per day (Rangan et al., 2011). Segmentation of the global BoP market by living standard is illustrated below in Figure 2.6.

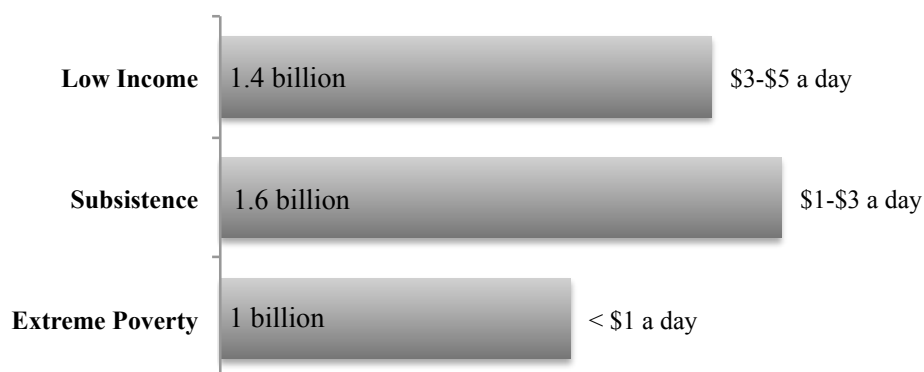


Figure 2.6: Segmentation of the BoP Market by Living Standard (SOURCE: Rangan et al., 2011)

Once the market has been divided, it is possible to analyse characteristics within each of these segments. Differences exist among adults and families within each of the respective segments in areas such as education level attained, job or technical skills, typical vocations and basic needs. For example, adults in the low income segment typically have a couple years of secondary education. However, adults in the subsistence segment tend to be poorly educated, and those in the extreme poverty segment commonly face limited education (Rangan et al., 2011). Families in the low income segment frequently strive for higher education, better paying work and good housing whereas families in the subsistence segment often need improved sanitation, health care and education. However, families in the extreme poverty segment normally lack even the most basic necessities such as sufficient food, clean water and adequate shelter (Rangan et al., 2011). The basic differences among the three segments are summarised in the following table.

Segment	Education	Skills	Vocations	Basic Needs
Low Income \$3-\$5 a day	Secondary education	Vocational skills	Construction workers, traders, drivers, low level staff	Higher education, better-paying work, good housing, access to credit, health care specialists
Subsistence \$1-\$3 a day	Poorly educated	Low skills	Day laborers, temp workers, helpers/assistants in petty trade, temporary-migratory farmhands	Improved sanitation, health care, access to credit, education
Extreme Poverty < \$1 a day	Limited education	Lack of skills	Subsistence farmers, bonded laborers	Lacks basic necessities such as sufficient food, clean water and adequate shelter

Table 2.3: Characteristics of the BoP Market by Income Segment (SOURCE: Rangan et al., 2011)

Understanding income segment characteristics is vital for targeting BoP markets. For example, Gilead, a global pharmaceutical supplier of antiretrovirals, has been very successful in targeting the low income segment of the BoP market. To do this, the company has provided access to two of its patents to Indian and South African generic drug companies. Instead of charging a technology transfer fee, Gilead sought only a 5% royalty on the selling price of the generic versions of the drugs. This strategy provided Gilead quick access to BoP markets in Asia and Africa, and the company was able to reach more than 1.4 million patients by 2010 (Rangan et al., 2011).

Roshan, an Afghan mobile network operator, provides an example of a company that has successfully targeted the subsistence segment. The company's network in Afghanistan has grown to more than 3,500 outlets with a subscriber base of approximately 3.5 million customers by encouraging Afghans to directly distribute SIM cards and handsets to other consumers. Due to ongoing security threats from the Taliban, Roshan recruits community leaders to protect its towers in exchange for training, jobs and security fees. The company has further created value by directly or indirectly employing 30,000 people (Rangan et al., 2011).

Finally, Global Alliance for Improved Nutrition (GAIN) is an example of an alliance that comprises organisations targeting the extreme poverty segment. Organisations that are part of the GAIN alliance target the extreme poverty segment by addressing world hunger and malnutrition. To do this, organisations collaborate with global food companies such as Unilever and Cargill to develop enriched food products. As a result, organisations part of the alliance GAIN helps ensure grains sold in various BoP markets in Asia and Africa are fortified with essential vitamins and minerals (Rangan et al., 2011).

In summary, leading authors explain that the BoP market is not a monolith (Hammond et al., 2007; London and Hart, 2011; Prahalad, 2004; Rangan et al., 2011). Therefore, income segmentation is central to understanding diverse BoP market characteristics. As mentioned earlier, the WRI-IFC study provides a significant empirical backdrop for income segmentation of the BoP market in the literature, and it evaluates BoP market segmentation in other ways as well. Further, the current research study takes place in Afghanistan, which is part of Central Asia, and the BoP market in the Asia region differs in various ways from other regions such as Eastern Europe or Latin America. Thus, regional segmentation of the BoP market is analysed in the following section.

2.2.2 Regional Profiles

Regional profiles of the BoP market are included here for Asia (includes Middle East), Africa, Eastern Europe and Latin America. The data represented below was collected from household surveys in each region. Twenty-two countries were surveyed in Africa, 19 countries were surveyed in Asia, 28 countries were surveyed in Eastern Europe and 21 countries were surveyed in Latin America (Hammond et al., 2007). Population of the BoP demographic, share of the total population represented by the BoP demographic, aggregate size of the BoP market by income and share of aggregate income represented by the BoP market are provided for each region, and disparities among the four regions are highlighted. In particular, examining comparative data is helpful for understanding context of the Afghanistan BoP market because no household survey data was available for Afghanistan.

2.2.2.1 Africa, Asia, Eastern Europe & Latin America

In Africa, the BoP demographic consists of 486 million people, which represents 95% of the population in countries surveyed. The size of the BoP market in Africa is \$429 billion. This represents 71% of the region's aggregate income. Although the BoP demographic represents the majority of the population in the Africa region, the BoP market makes up a smaller share of the region's aggregate income. The BoP market does not make up as large of a share of regional aggregate income as the size of the BoP demographic might suggest. However, it still represents a significant portion of the total. When taking a closer look at the BoP market, income is not spread evenly among the six income segments. In the Africa BoP market, income is concentrated in the BOP1500, BOP1000 and BOP500 segments. Therefore, the Africa BoP market can be considered bottom heavy (Hammond et al., 2007).

In Asia (including the Middle East), the BoP demographic consists of a population of 2.86 billion people in the countries surveyed. This represents 83% of the region's total population. With an aggregate regional income of over \$8 trillion, the BoP market makes up 42% of this total. The BoP demographic in Asia (including the Middle East) represents the majority share of the population in that region. However, the BoP market makes up a reasonably smaller share of the region's aggregate income. Although the Asia BoP market only represents 42% of the regional aggregate income, this market still provides significant potential due to the massive size of aggregate income in Asia. When viewing segmentation of the BoP market, income is not spread evenly among the six income segments. Income in the Asia BoP market is concentrated in the BOP2000,

BOP1500 and BOP1000 segments. However, the greatest concentration is in the BOP1500 and BOP1000 so the overall market is relatively bottom heavy (Hammond et al., 2007).

In Eastern Europe, the BoP demographic consists of a population of 254 million people in the countries surveyed. This represents 64% of the total population in the region. The BoP market in the Eastern Europe region is valued at \$458 billion, which represents 36% of the region's aggregate income. The BoP demographic in Eastern Europe represents almost two-thirds of the population in that region. Conversely, the BoP market only makes up approximately one-third of the aggregate income in Eastern Europe. Although the BoP demographic represents the majority of the population in Eastern Europe, the BoP market is much smaller in comparison to the regional aggregate income. Further, when analysing segmentation of the BoP market in Eastern Europe, income is unevenly distributed across the six income segments. Income in the Eastern Europe BoP market is concentrated in the BOP3000, BOP2500 and BOP2000 segments. Because the greatest concentration is in the upper income segments of the BoP market, the overall market can be considered top heavy (Hammond et al., 2007).

In Latin America (including the Caribbean), the BoP demographic includes 360 million people in countries surveyed. This represents 70% of the total population in that region. The size of the BoP market in Latin America is \$509 billion, which accounts for 28% of household income in the region. The BoP demographic makes up the majority of the population in Latin America whereas the BoP market accounts for only a small fraction of the regional household income. Although the BoP market in Latin America accounts for only 28% of household income in the region, this still represents a sizable potential due to the overall size of the market. In the Latin America BoP market, income is concentrated in the BOP3000, BOP2500, BOP2000 and BOP1500 segments. Income in this region is highly concentrated in the upper income segments. Therefore, the Latin America BoP market can be considered top heavy (Hammond et al., 2007).

2.2.2.2 Regional Differences

It is necessary to understand the structure of the BoP market in each of the four regions, but it is not enough to simply analyse each region in isolation. Underscoring similarities and differences concerning the BoP market among the four regions is also important. As mentioned earlier, understanding characteristics of the various BoP market segments can help organisations more effectively target the BoP market. Data for comparison of the four regions is provided in the following table.

Region	BoP Demographic (millions)	% of Total Population	BoP Market (millions)	% of Aggregate Income	BoP Segment Concentration
Africa	486	95%	\$429	71%	Bottom Heavy
Asia	2,860	83%	\$3,470	42%	Bottom Heavy
Eastern Europe	254	64%	\$458	36%	Top Heavy
Latin America	360	70%	\$509	28%	Top Heavy

Table 2.4: Regional Data from Countries Surveyed (SOURCE: Hammond et al., 2007)

In regard to the BoP demographic, Asia has by far the largest population. The size of the BoP demographic in Asia exceeds the BoP demographic in Africa by more than five times and in Eastern Europe by more than 11 times. The BoP demographic in Africa comprises almost the entire population (95%), and the BoP demographic in Asia encompasses almost as much (83%). Although the BoP demographic in Eastern Europe and Latin America do not make up as great of a percentage of the total population as the BoP demographic in Africa or Asia, both still represent a majority of the population in each respective region (Hammond et al., 2007). A comparison of the size of the BoP demographic and percentage of the respective total regional population is illustrated for the four regions in the following figure.

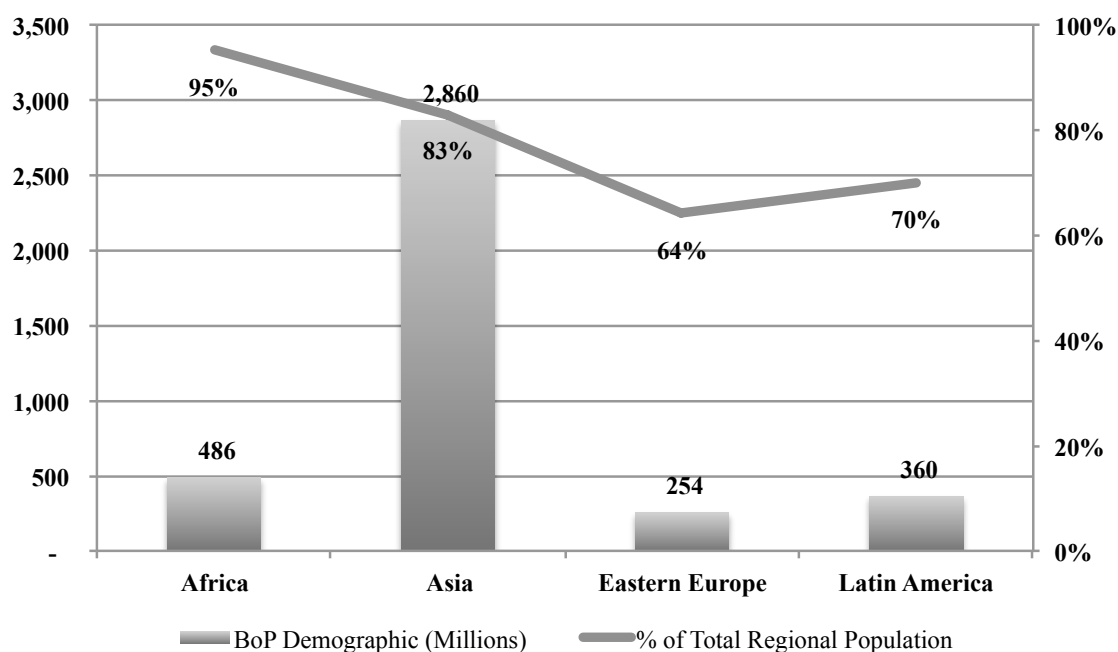


Figure 2.7: BoP Demographic Comparison by Region (SOURCE: Hammond et al., 2007)

Concerning the BoP market, the Asia region also has the largest market size. It is over eight times the size of the Africa BoP market and is almost seven times the size of

the Eastern Europe BoP market. Although the Africa BoP market is the smallest of the four markets, it accounts for the largest percentage of regional aggregate income (71%) compared to Asia (42%), Eastern Europe (36%) and Latin America (28%). The reason for this large disparity is related to the concentration of income in the lowest of the six income segments (Hammond et al., 2007). A regional breakdown of the BoP market along with percentage share of the respective aggregate regional income is compared in the figure below.

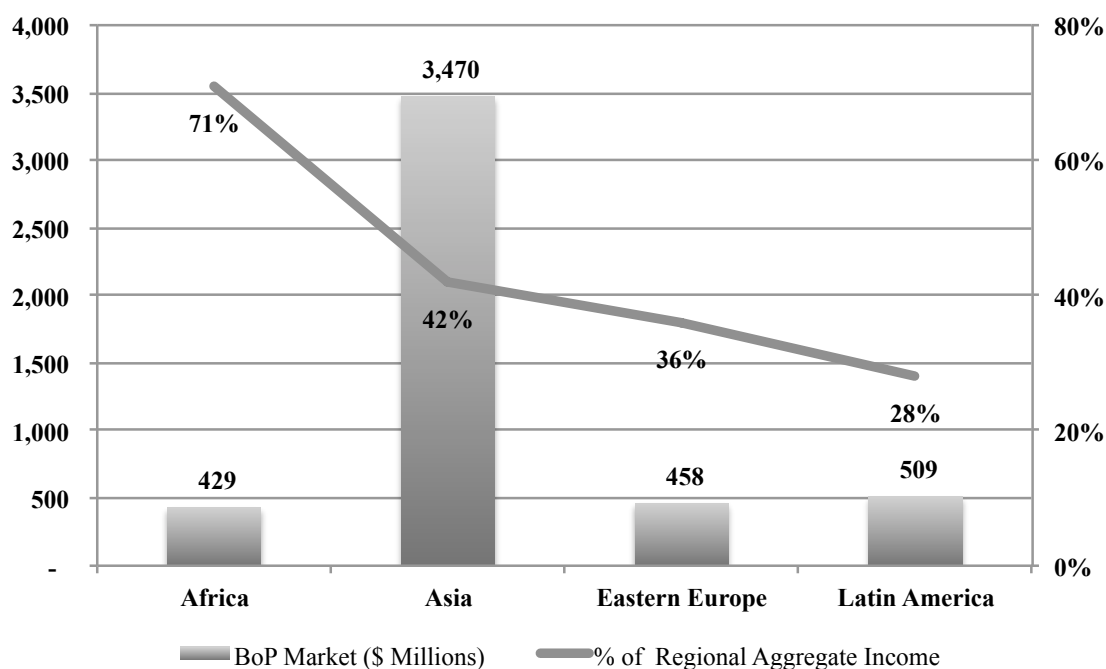


Figure 2.8: BoP Market Comparison by Region (SOURCE: Hammond et al., 2007)

Finally, the composition of the BoP market in each of the regions is different. The BoP market in Africa and Asia is bottom heavy while the BoP market in Eastern Europe and Latin America is top heavy. For example, income is concentrated in the BOP1500, BOP1000 and BOP500 segments in the Africa BoP market. Of the four regions, the Africa BoP market has the greatest concentration of income in the lowest segments (Hammond et al., 2007).

Income in the Asia BoP market is concentrated in the BOP2000, BOP1500 and BOP1000 segments with the greatest concentration in the BOP1500 and BOP1000. It is a bottom heavy market but not as much as the Africa BoP market. Income in the Eastern Europe BoP market is heavily concentrated in the BOP3000 and BOP2500 segments. In fact, the Eastern Europe BoP market is the most top heavy market of the four regions. Although the Latin America BoP market is top heavy, income is somewhat evenly concentrated in all segments except the BOP500 segment (Hammond et al., 2007).

Several findings from the comparisons above are important for the current research study. First, with a large percentage of the overall population in the Asia region included in the BoP demographic (83%), it is likely that this percentage of the population represented by the BoP demographic in Afghanistan would also be similar and possibly even higher. Second, although the Asia BoP market is large in size, it only represents 42% of the regional aggregate income. Therefore, it is probable that the Afghanistan BoP market accounts for a larger percentage of the country's aggregate income compared to the average for the Asia region due to Afghanistan's recent economic history.

As mentioned above, Asia is a bottom heavy market with the greatest concentration of income in the BOP1500 and BOP1000 segments (Hammond et al., 2007). Based on segmentation of the Asia BoP market, it could be expected that the Afghanistan BoP market would be bottom heavy. These comparisons are useful for benchmarking and understanding the Afghanistan BoP market due to the lack of household survey data available for the country. However, regional data is broad and BoP markets across different countries within the Asia region can vary. Therefore, it is crucial to further examine the BoP market within countries adjacent to Afghanistan.

2.2.3 National Characteristics

The countries of Bangladesh, India, Nepal, Pakistan, Tajikistan and Uzbekistan are included in the following analysis because they are the nations included in the WRI-IFC study that are closest in proximity and culture to Afghanistan. Although BoP markets in these countries will not exactly mirror the BoP market in Afghanistan, analysing BoP market segmentation within these nations provides a means of comparison for estimating the Afghanistan BoP market. In the following assessment, population of the BoP demographic as a share of the total population, population of the BoP demographic by income segment, percentage of the BoP demographic living in urban versus rural areas, size of the BoP market (measured by annual expenditure) as a share of national household spending, percentage share of spending in the BoP market by income segment and share of spending in urban versus rural areas accounted for by the BoP market are included for each country. Findings from the six-country group are summarised and compared in order to glean common characteristics that may be indicative of the Afghanistan BoP market.

2.2.3.1 Bangladesh, India, Nepal, Pakistan, Tajikistan & Uzbekistan

The BoP demographic in Bangladesh includes 125.4 million people, which represents 99.6% of the total population. The BOP1000 segment accounts for roughly half of the entire population of Bangladesh, and the BOP500 segment accounts for approximately one quarter of the total population. In fact, the bottom three income segments – BOP1500, BOP1000 and BOP500 – collectively represent over 90% of the entire population. Further, a large percentage of the BoP demographic in Bangladesh live in rural areas. Over two-thirds of the BOP1000 segment live in rural areas, and almost three-fourths of the BOP500 segment live in rural areas. On the other hand, only 11.1% of the BOP3000 segment and 9.5% of the BOP2500 segment live in rural areas. Thus, the majority of the BoP demographic in the upper income segments live in urban parts of Bangladesh (Hammond et al., 2007).

The size of the BoP market in Bangladesh measured by household expenditure is approximately \$105.3 billion, which represents 96.9% of the overall size of the market. Not only does the BOP1000 segment represent the largest percentage of the total population, it also accounts for the greatest portion of household spending. However, whereas the BOP500 segment represented almost one quarter of the total population, it accounts for less than half of that much on a percentage basis – about 12% – in regard to household spending. Instead, the BOP1500 makes up the second largest segment in regard to spending with 21.6% of the total (Hammond et al., 2007).

The BoP market in Bangladesh accounts for almost all household spending in the country. Although the BoP market represents such an overwhelming majority of the overall market, spending is not distributed evenly across the six segments. In the BoP market in Bangladesh, household expenditure is concentrated in the BOP2000, BOP1500 and BOP1000 segments. However, the greatest concentration of spending is in the BOP1500 and BOP1000 segments. Therefore, the Bangladesh BoP market can be considered bottom heavy. Spending is further concentrated in rural areas. For example, in the BOP1500 and BOP1000 segments, 84.3% and 93% of spending occurred in rural areas, respectively. Therefore, the overall BoP market can be considered both bottom heavy and rural (Hammond et al., 2007).

India is the second largest country in the world by population. Likewise, the BoP demographic in India is massive. It includes 924.1 million people, which represents 95% of the total population. The BOP1500 and BOP1000 include 309 million people and 349 million people, respectively. This comprises over two-thirds of the entire population. On the other hand, the remaining four segments collectively account for just

over a quarter of the total population. A large portion of the BoP demographic in India live in rural areas. For example, over 80% of the BOP1500 segment and more than 90% of the BOP1000 segment live in rural areas. Overall, 78% of the total BoP demographic live in rural areas. A majority of the BoP demographic in the BOP3000 and BOP2500 income segments in India do live in urban areas. However, these segments only account for 3.2% and 7% of the total population, respectively (Hammond et al., 2007).

The size of the BoP market in India measured by household expenditures is \$1.2 trillion. This accounts for 84.8% of the aggregate size of the India market. Whereas the BOP1500 and BOP1000 segments account for over two-thirds of the total population, these segments combined make up less than 50% of aggregate household expenditures. In contrast, the BOP3000 and BOP2500, which collectively make up about 10% of the entire population, make up 17.5% of total household spending. Thus, on a percentage basis, spending is greater in the upper income segments relative to the population of these segments (Hammond et al., 2007).

Accounting for almost 85% of all household expenditure, the BoP market in India comprises a majority of the overall market. However, spending is somewhat unevenly distributed across the six segments. For example, household expenditure is concentrated in the BOP2000, BOP1500 and BOP1000 segments with the greatest concentration in the BOP1500 and BOP1000 segments. The India BoP market can be considered bottom heavy. However, it is interesting to note that spending in the BOP500 segment is virtually nonexistent compared to the other segments. Spending is further concentrated in rural areas. The rural BoP market in India is over 2.2 times the size of the urban BoP market. In the BOP1500 and BOP1000 segments, 71.8% and 86.2% of spending occurred in rural areas, respectively. Therefore, the overall BoP market can be considered bottom heavy and rural (Hammond et al., 2007).

In Nepal, the BoP demographic includes only 23 million people, but this represents 97.3% of the total population. The BOP1000 segment accounts for almost half of the population of Nepal, and the BOP500 segment accounts for nearly one third of the total population. Collectively, the BOP1500, BOP1000 and BOP500 segments comprise over 90% of the entire population. The vast majority of the BoP demographic in Nepal live in rural areas. For example, 82.1% of BOP1500 segment, 93.7% of the BOP1000 segment and 97% of the BOP500 segment live in rural parts of Nepal. Overall, 89.1% of the total BoP demographic live in rural areas. Although 100% of the BOP3000 and 74.8% of the BOP2500 live in urban areas, these segments make up less than 3% of the total population (Hammond et al., 2007).

The size of the BoP market in Nepal measured by household expenditure is approximately \$18.7 billion, which represents 85.4% of the overall size of the market. There is a disparity between the share of the population and share of household expenditures represented by each segment in Nepal. The bottom two income segments account for a greater percentage of the total population but a lesser percentage of household expenditure in comparison. For example, the BOP1000 and BOP500 segments account for 45.8% and 29.9% of the total population, respectively. However, the same segments account for only 36.7% and 13% of aggregate household expenditures. The opposite relationship is true for the upper income segments. The BOP3000 and BOP2500 segments make up 0.9% and 2% of the total population, respectively, but comprise 2.8% and 5.2% total household spending (Hammond et al., 2007).

The BoP market in Nepal accounts for the majority of household spending in the country. Although the BoP market represents such an overwhelming majority of the overall market, spending is not distributed evenly across the six segments. In the BoP market in Nepal, household expenditure is concentrated in the BOP1500, BOP1000 and BOP500 segments with the greatest concentration in the BOP1500 and BOP1000 segments. Therefore, the Nepal BoP market can be considered bottom heavy. Overall, only 19.5% of household spending occurred in urban areas in the Nepal BoP market whereas 80.5% of spending occurred in rural areas. The rural BoP market in Nepal is over 4.1 times larger than the urban BoP market. Further, in the BOP1500, BOP1000 and BOP500 segments, 81.3%, 93.4% and 96.9% of spending was concentrated in the rural parts of Nepal, respectively. Thus, the BoP market is bottom heavy and highly rural (Hammond et al., 2007).

The BoP demographic in Pakistan includes 129 million people, which represents nearly 100% of the total population. The BOP1000 segment accounts for roughly half of the entire population of Pakistan, and the BOP500 segment accounts for approximately one third of the total population. The bottom three income segments – BOP1500, BOP1000 and BOP500 – collectively represent over 96% of the entire population. Further, over 70% of the BoP demographic in Pakistan live in rural areas. In the BOP1000 segment and BOP500 segment, 71.3% and 83.4% live in rural areas, respectively. Conversely, only 2% of the BOP3000 segment and 9.2% of the BOP2500 segment live in rural areas. Thus, the majority of the BoP demographic in the upper income segments live in urban parts of Pakistan. However, these upper income segments comprise only a small share of the overall population (Hammond et al., 2007).

The size of the BoP market in Pakistan measured by household expenditure is approximately \$97.9 billion, which represents 98.9% of the overall size of the market. In Pakistan, not only does the BOP1000 segment represent the largest percentage of the total population, it also accounts for the greatest portion of household spending. Likewise, the BOP500 segment is the second largest segment of the total population and also represents the second largest segment in regard to spending. However, the BOP500 segment accounts for a much smaller percentage of aggregate spending (19.5%) compared to the share of population (34.4%). In contrast, the top four income segments account for a larger percentage of aggregate expenditures compared to their share of the total population (Hammond et al., 2007).

Although the BoP market accounts for almost the entire market in Pakistan, spending is not distributed evenly across the six segments. In the Pakistan BoP market, household expenditure is concentrated in the BOP1500, BOP1000 and BOP500 segments with the greatest concentration in the BOP1000 segment. Therefore, the BoP market in Pakistan can be considered bottom heavy. Although 98.1% spending in the BOP3000 segment and 91% of spending in the BOP2500 segments occurs in urban areas, the two combined segments account for less than 5% of aggregate spending. Overall, the Pakistan BoP market is predominantly rural with almost two-thirds of spending occurring in rural areas. While the BoP market is principally rural, the rural market is not significantly larger than urban market. The rural BoP market is only about 1.8 times larger than the urban market. Therefore, the overall BoP market can be considered bottom heavy and primarily rural (Hammond et al., 2007).

In Tajikistan, the BoP demographic is small. It includes only 6.6 million people, but this represents 99.7% of the entire population. The BOP1000 segment accounts for approximately half of the population of Tajikistan, and the BOP500 segment accounts for almost one quarter of the total population. Collectively, the BOP1500, BOP1000 and BOP500 segments comprise over 91% of the entire population. The majority of the BoP demographic in Tajikistan live in rural areas. For example, 68.2% of BOP1500 segment, 75.2% of the BOP1000 segment and 79.5% of the BOP500 segment live in rural parts of Tajikistan. Overall, nearly three quarters of the total BoP demographic live in rural areas. Although 70.9% of the BOP3000 and 56.3% of the BOP2500 live in urban areas, these segments make up only 2% of the total population (Hammond et al., 2007).

The size of the BoP market in Tajikistan measured by household expenditure is approximately \$7.4 billion, which represents 98.9% of the overall size of the market. In Tajikistan, the BOP1000 segment represents the largest percentage of the total

population (49.9%) as well as the greatest portion of household spending (42.9%). Conversely, whereas the BOP500 segment is the second largest segment of the total population (22.6%), it accounts for less than half that much in regard to aggregate spending (10.4%). Instead, the BOP1500 represents the second largest segment in regard to spending at 27.4% of the aggregate (Hammond et al., 2007).

Accounting for almost 99% of all household expenditure, the BoP market in Tajikistan comprises a vast majority of the overall market. However, spending is unevenly distributed across the six segments. Household expenditure is concentrated in the BOP1500 and BOP1000 segments with the greatest concentration in the BOP1000 segment. There is very little concentration of spending in the BOP3000 and BOP2500 segments. Therefore, the BoP market in Tajikistan can be considered bottom heavy. Further, the Tajikistan BoP market is predominantly rural with almost 70% of spending occurring in rural areas. Although 71.6% of spending in the BOP3000 segment occurs in urban parts of Tajikistan, the segment only accounts for 1.6% of aggregate spending. In comparison, the BOP1000 segment accounts for 42.9% of aggregate spending and 74.9% of spending in this segment occurs in rural areas. Therefore, the overall BoP market can be considered bottom heavy and rural (Hammond et al., 2007).

The BoP demographic in Uzbekistan includes 23.7 million people, which represents 99.5% of the total population. The BOP1000 segment accounts for almost half of the population of Uzbekistan, and the BOP500 segment accounts for over one third of the total population. Collectively, the bottom three income segments – BOP1500, BOP1000 and BOP500 – represent over 94% of the entire population. The majority of the BoP demographic in Uzbekistan in the top four income segments live in urban areas. For example, 88.9% of the BOP3000 segment and 90.2% of the BOP2500 segments live in urban areas. However, the BOP1000 segment and BOP500 segments collectively make up 83.2% of the total population. In these segments, 67.4% and 74.4% live in rural areas, respectively. As a result, nearly two thirds of the total BoP demographic live in rural areas (Hammond et al., 2007).

The size of the Uzbekistan BoP market measured by household expenditure is approximately \$23.1 billion, which represents 96.7% of the overall size of the market. In Uzbekistan, the BOP1000 segment represents the largest percentage of the total population (48.7%) as well as the greatest portion of household spending (47%). Conversely, whereas the BOP500 segment comprises 34.5% of the total population, it accounts for little over half that much in regard to aggregate spending (17.5%). Further,

the bottom three segments represent 83.6% of aggregate spending (Hammond et al., 2007).

The BoP market in Uzbekistan accounts for 96.7% of aggregate household spending in the country. Although the BoP market accounts for almost the entire market in Uzbekistan, spending is not distributed evenly across the six segments. Household expenditure is concentrated in the BOP1500, BOP1000 and BOP500 segments with the greatest concentration in the BOP1000 segment. There is very little concentration of spending in the BOP3000, BOP2500 or BOP2000 segments. Therefore, the BoP market in Uzbekistan can be considered bottom heavy. Further, spending is spread relatively evenly across urban and rural areas. In Uzbekistan, 45.3% of spending occurred in urban areas versus 54.7% in rural areas. Spending in the top four segments occurred primarily in urban areas. For example, 88.9% of spending in the BOP3000 segment and 90.6% of spending in the BOP2500 segment was concentrated in urban areas. A small majority of spending did take place in rural parts of Uzbekistan due to the proportion of the population in the BOP1000 and BOP500 segments. The result is that the size of the rural BoP market is only marginally larger than the urban market. As a result, the overall BoP market can be considered bottom heavy and equally urban and rural (Hammond et al., 2007).

2.2.3.2 Cross-Country Comparison

Examining what is known about the various nations that are closest in proximity and culture to Afghanistan is necessary because no data is available for the BoP market in this country. The side-by-side comparison highlights similarities and differences among the six nations included in the previous analysis. This comparative data is useful for making inferences concerning the structure of the Afghanistan BoP market. The following map illustrates the proximity of the six countries to Afghanistan.



Figure 2.9: Geographic Proximity of Countries Included in the Comparison (SOURCE: Author)

The populations of the six countries range from just 6.7 million in Tajikistan to 973 million in India. Nepal and Uzbekistan have similar populations of 23.6 million and 23.8 million, respectively. Bangladesh and Pakistan also have comparable populations of 126 million and 129 million, respectively. The BoP demographic in each country, as a percentage of the total population, ranges from 95% in India to 100% in Pakistan. The percentage of the BoP demographic of each country living in rural areas ranges from 63.5% in Uzbekistan to 89.1% in Nepal. The following figure illustrates the comparisons.

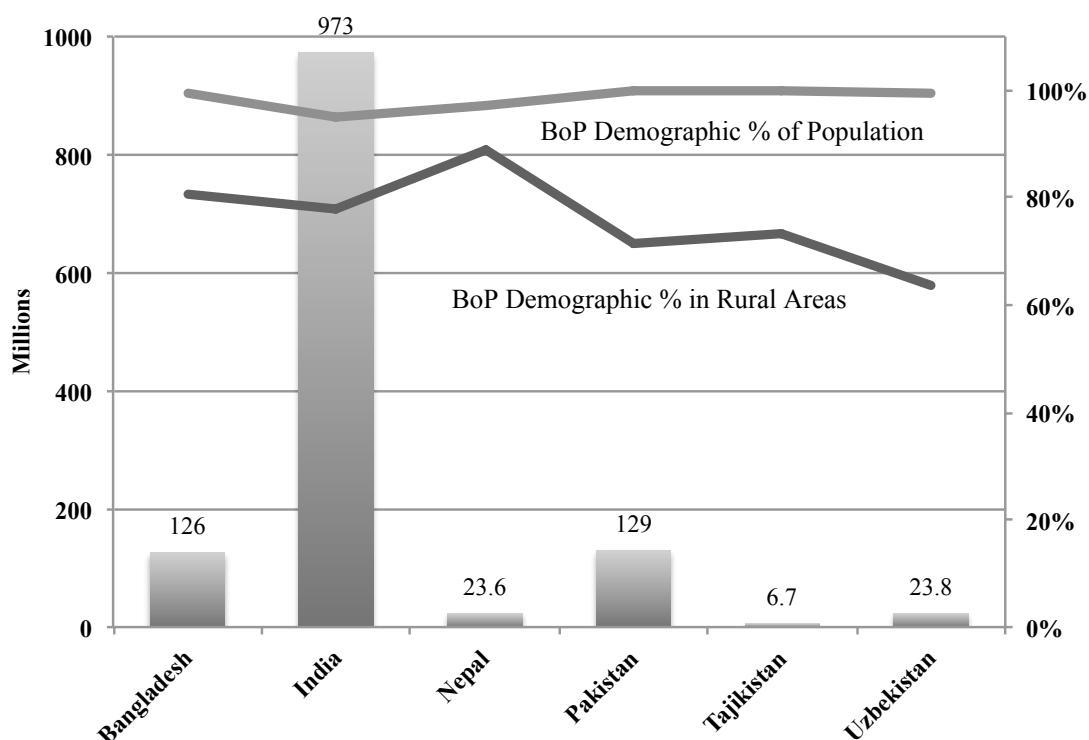


Figure 2.10: BoP Demographic – Country Comparison (SOURCE: Hammond et al., 2007)

In each of the countries included in the analysis, the BOP1000 is the largest segment in regard to population. The percentage of the total population accounted for by the BOP1000 segment ranges from 35.9% in India to 52.6% in Bangladesh. The BOP500 was the second largest segment in every country except India and ranges from 22.6% of the total population in Tajikistan to 34.5% of the population in Uzbekistan. In India, the BOP1500 segment was the second largest segment making up 31.8% of the population. Similarly, the BOP1500 was the third largest segment in each country excluding India. This segment ranged from 9.8% of the population in Pakistan to 19.1% of the population in Tajikistan. The third largest segment in India was the BOP2000 segment, which represented 15.1% of the population.

Consequently, the three bottom segments are the largest segments in each country except India. In fact, among the five countries excluding India, the bottom three segments account for between 90.3% and 96.5% of the population. This is almost the entire population in five out of the six countries analysed. A breakdown of the six segments in each country is illustrated below. The percentage of each of the three largest segments in each country is included.

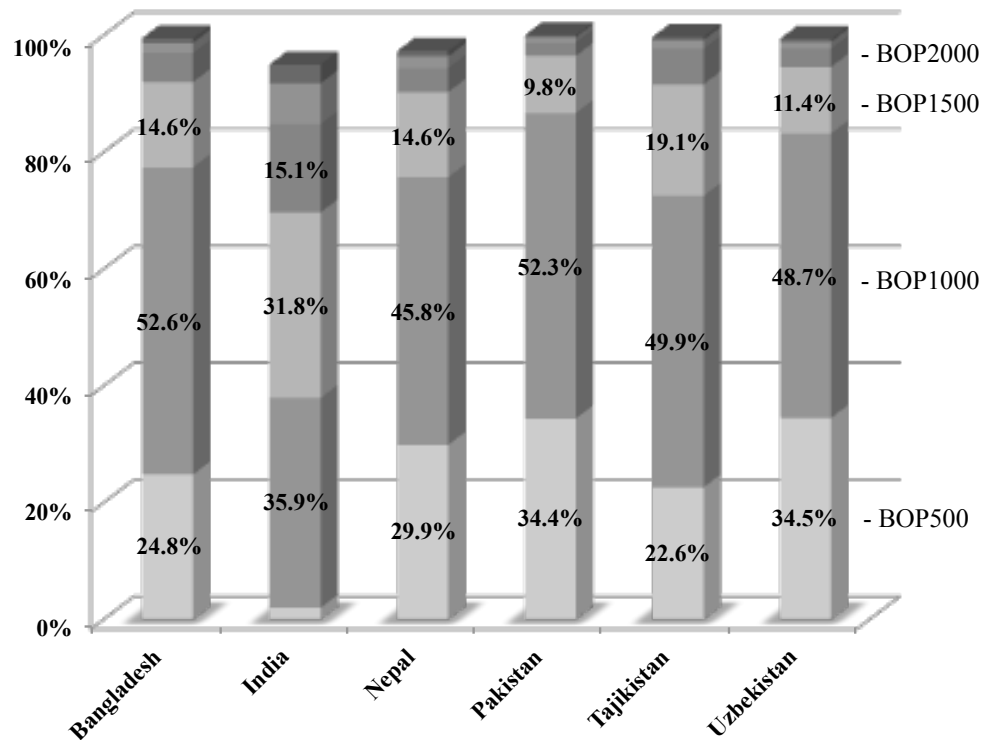


Figure 2.11: BoP Demographic by Segment – Country Comparison (SOURCE: Hammond et al., 2007)

The aggregate market size measured by household expenditures ranges from only about \$7.5 billion in Tajikistan to approximately \$1.4 trillion in India. The aggregate markets in Nepal and Uzbekistan are similarly sized at approximately \$21.9 billion and \$23.1 billion, respectively. The total market in Bangladesh and Pakistan is also comparably sized at around \$100 million in each country. The BoP market in each country, as a percentage of aggregate expenditures, ranges from 84.8% in India to 98.9% in Pakistan. The percentage of spending within the BoP market occurring in rural areas ranges from 54.7% in Uzbekistan to 80.5% in Nepal. The following figure illustrates the comparisons.

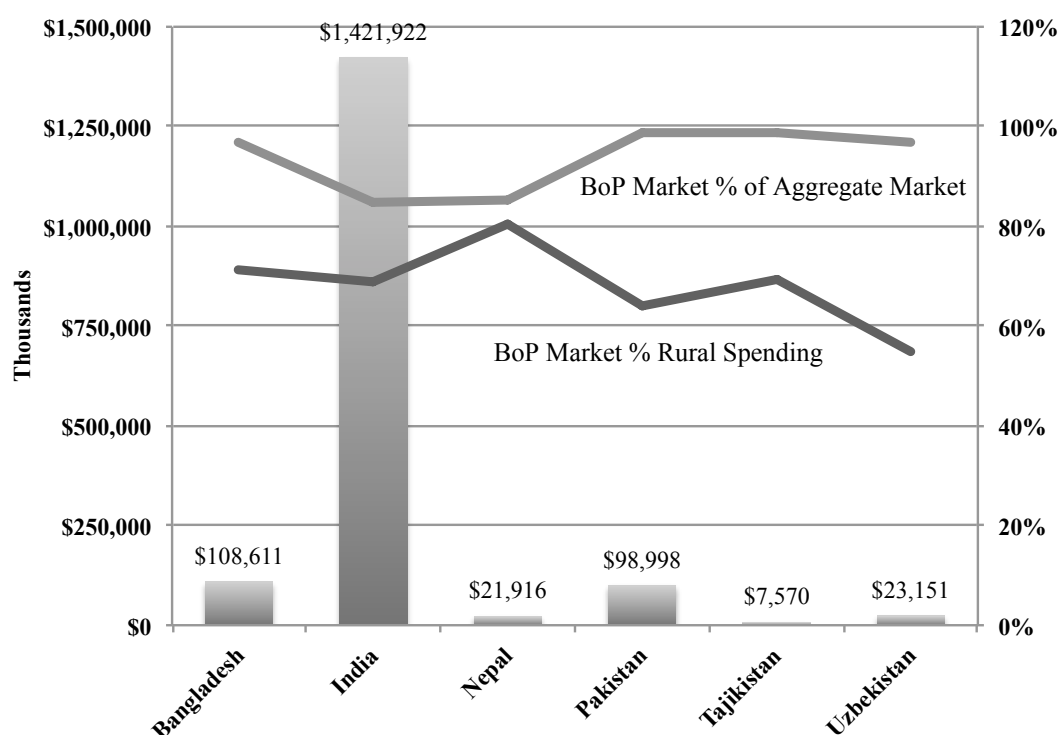


Figure 2.12: BoP Market – Country Comparison (SOURCE: Hammond et al., 2007)

The BOP1000 is the largest segment in regard to market size in each country except India. The percentage of the total market accounted for by the BOP1000 segment ranged from 36.7% in Nepal to 52.6% in Pakistan. In India, the BOP1500 segment is the largest segment comprising 27.8% of the size of the market. The BOP1500 is the second largest segment in four out of the six countries evaluated and ranged from 19.8% of the market in Nepal to 27.4% in Tajikistan. The second largest segment in India is the BOP1000, and the second largest segment in Pakistan is the BOP500.

The BOP500 is the third largest segment in Bangladesh, Nepal and Uzbekistan accounting for 12.2%, 13% and 17.5% of the total market, respectively. However, the BOP2000 is the third largest segment for India and Tajikistan, and the BOP1500 is the third largest segment for Pakistan. A breakdown of the six segments in each country is illustrated below. The percentage of each of the three largest segments in each country is labelled in the figure.

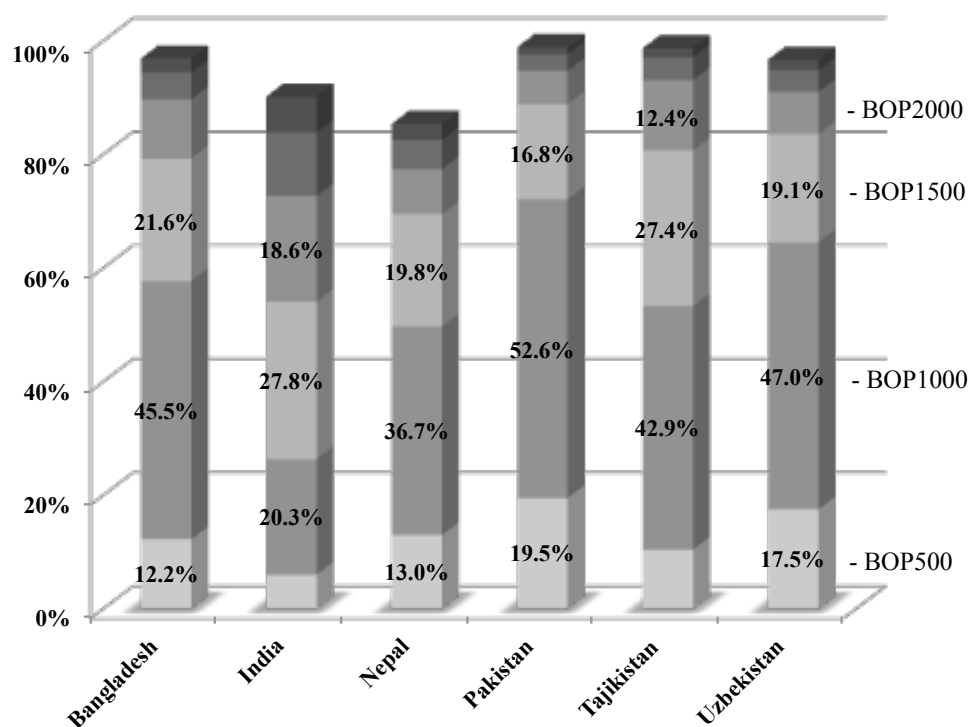


Figure 2.13: BoP Market by Segment – Country Comparison (SOURCE: Hammond et al., 2007)

Although spending is not distributed evenly across the six segments for each country, there are consistent patterns. Therefore, it is interesting to look at distribution of spending for the six-country region as a whole. Distribution of spending across the six BoP segments is illustrated in the figure below.



Figure 2.14: Six-Country Region BoP Market by Spending (SOURCE: Hammond et al., 2007)

Due to the massive size of the India BoP market, the shape of the figure above is skewed heavily towards that market. It does not closely represent the average for the other five countries. For example, the BOP1000 is the largest segment for every country except India. However, the figure above shows the BOP1500 as the largest segment simply due to the size of the India market (Hammond et al., 2007). Therefore, it is helpful to look instead at the five-country region by excluding India. This distribution across the six BoP segments is shown in the following figure.



Figure 2.15: Five-Country Region BoP Market (Ex-India) by Spending (SOURCE: Hammond et al., 2007)

As mentioned above, the BOP1000 is the largest segment followed by the BOP1500 and BOP500 segments. The BOP2000 market is the fourth largest segment. The distribution in the latter figure more accurately represents the average distribution for the data across most of the countries included in the assessment whereas the former closely mirrors the shape of the distribution for the India BoP market. Therefore, the latter distribution is a better representation of the average for five out of the six countries in the region.

In summary, there are several notable differences among the countries analysed that need to be highlighted. First, the BoP demographic accounts for almost the entire population in each country included in the analysis. Second, the BOP1000 is most commonly the largest segment in regard to both population and market size. However, whereas the BOP500 is the second largest segment in regard to population in five out of the six countries, the BOP1500 is the second largest segment in regard to market size in four out of the six countries. In particular, India varied from the group norm in regard to both population and market size.

Third, although population size of the BoP demographic is highly concentrated in the bottom three segments, the percentage of spending in these segments relative to aggregate expenditures is not as significant. Therefore, individual purchasing power, as a percentage of aggregate spending, is not as great in the bottom three segments when compared to the top three segments. Fourth, spending is smaller on a percentage basis in rural areas compared to the concentration of the BoP demographic living in these areas. This reveals that spending, on a percentage basis, is less concentrated in rural areas.

Finally, India is the most dissimilar country among those analysed. For instance, its population and market size are significantly larger than the others, and the BoP demographic and spending in India are concentrated in higher segments compared to the five other countries. Because the India BoP market varies consistently from the other

markets, it is probably the least accurate of the six countries to use as a benchmark for estimating the structure of the Afghanistan BoP market. Therefore, Bangladesh, Nepal, Pakistan, Tajikistan and Uzbekistan are used as the comparison group to estimate the Afghanistan BoP market. Further, in regard to culture, Pakistan and Tajikistan are most closely related to Afghanistan. This is due to ethnic Tajiks living in Afghanistan and the Pashtun tribe being geographically split between Afghanistan and Pakistan. To provide greater context for the research study, the structure of the Afghanistan BoP market is estimated in the following section by using data from the five-country group as well as additional external data from country and development reports concerning Afghanistan.

2.2.3.3 Afghanistan (Estimated)

It is not possible to determine the structure of the Afghanistan BoP market exactly because there is no household survey data available for the country, and Afghanistan was not included in the WRI-IFC study. However, the structure of the Afghanistan BoP market can be estimated using comparative data from the previous multi-country analysis as well as additional external sources. For comparison purposes, India is excluded because it consistently varies from the average of the six-country group above. Therefore, averages from the five-country group are used to estimate the structure of the Afghanistan BoP market. Further, data from external sources is used from the 2003-2006 time period when it is available because national expenditure data from the WRI-IFC study was collected from surveys that were standardised as a part of the 2003-2006 round of the International Comparison Programme. As a result, the following analysis provides a general picture of what the structure of the Afghanistan BoP market might look like based on averages from similar surrounding countries as well as additional country-level data on Afghanistan.

To estimate the size of the BoP demographic in Afghanistan, population data for Afghanistan is used along with the average percentage of the total population represented by the BoP demographic from the five-country group. In Afghanistan, the total population is approximately 25.5 million people (De Bruijn, 2014). The BoP demographic in the five-country group, as a percentage of the total population, ranges from 97.3% in Nepal to 100% in Pakistan. The average percentage of the total population represented by the BoP demographic among the five-country group is 99.2% (Hammond et al., 2007). Based on this data, it is possible that the size of the BoP demographic in Afghanistan exceeds 25 million people.

There is no segment data available for the BoP demographic (BOP3000, BOP2500, BOP2000, etc.) in Afghanistan. Therefore, the average percentage of the total population represented by each segment from the five-country group can be used to estimate the data for Afghanistan. For example, the average for the BOP3000 is 0.6% while the average for the BOP500 is 29.2% (Hammond et al., 2007). The following figure shows the estimated breakdown of the population in Afghanistan represented by the BoP demographic.

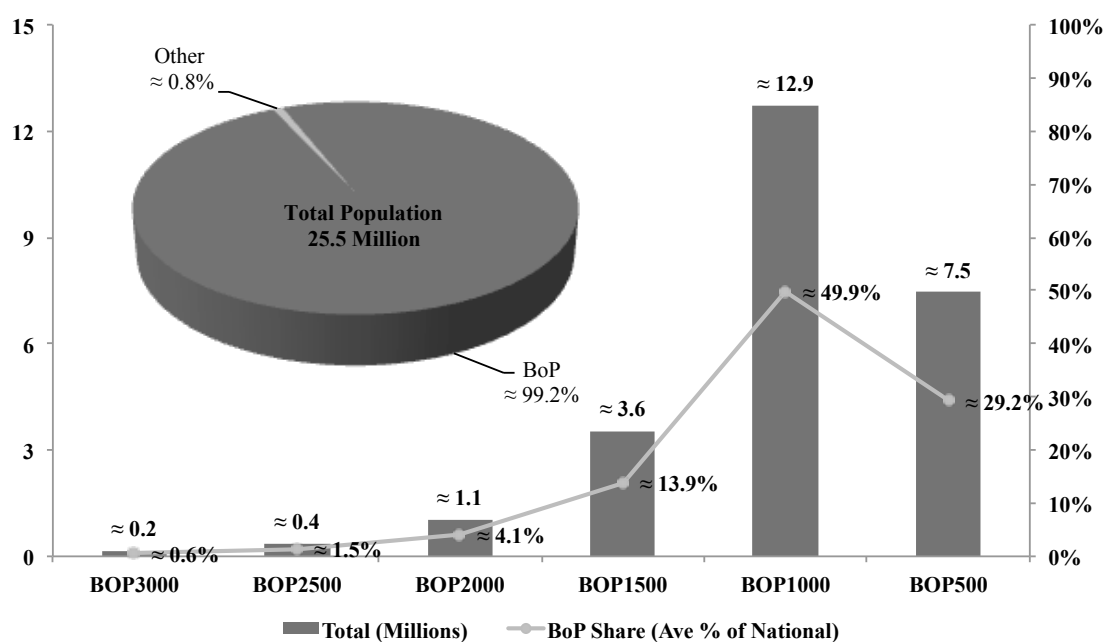


Figure 2.16: Afghanistan (Estimated) – Composition of the BoP Demographic (SOURCE: Author)

The Afghanistan National Development Strategy Report (ANDS) reports that 80% of the total population of Afghanistan lives in rural areas (Islamic Republic of Afghanistan, 2013). The average percentage of the BoP demographic living in rural areas among the five-country group is 75.5% (Hammond et al., 2007). Due to the large rural population in Afghanistan, it is probable that the percentage of the BoP demographic in Afghanistan living in rural areas is in line with, or greater than, the average of the five-country group. Because there is no segment data available for Afghanistan, the average percentage of the BoP demographic living in urban versus rural areas by segment from the five-country group is used to estimate the data. The estimated share of the BoP demographic in Afghanistan living in urban versus rural areas by segment is illustrated below.

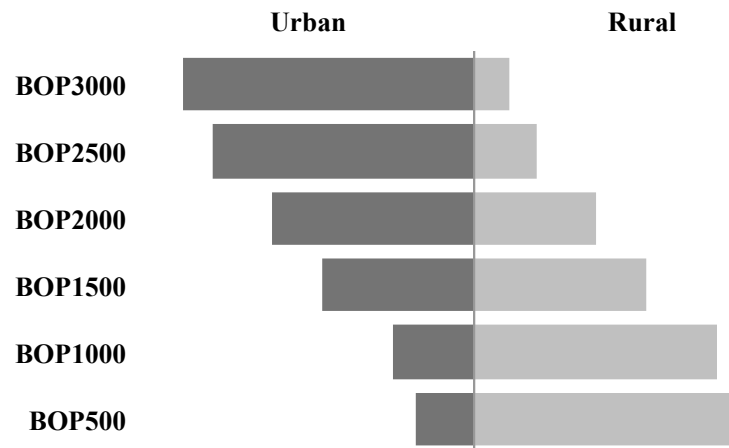


Figure 2.17: BoP Demographic (Afghanistan) – Estimated Urban/Rural Population (SOURCE: Author)

The size of the Afghanistan BoP market can be estimated using the five-country analysis from above along with World Bank data for total household expenditures in Afghanistan. According to the World Bank, aggregate household expenditures for Afghanistan in 2006 were approximately \$7.4 billion (The World Bank, 2013b). The average percentage of aggregate household expenditures accounted for by the BoP market ranged from 85.4% in Nepal to 98.9% in Pakistan. However, the average for the five-country group was 95.3%. Further, there is no segment data available (BOP3000, BOP2500, BOP2000, etc.) for the Afghanistan BoP market. Therefore, the average percentage of the total household expenditures represented by each segment for the five-country group is used to estimate the data. For example, the average for the BOP3000 among the five countries is 2% while the average for the BOP500 is 14.5% (Hammond et al., 2007). The following figure shows the estimated breakdown of the BoP market in Afghanistan.

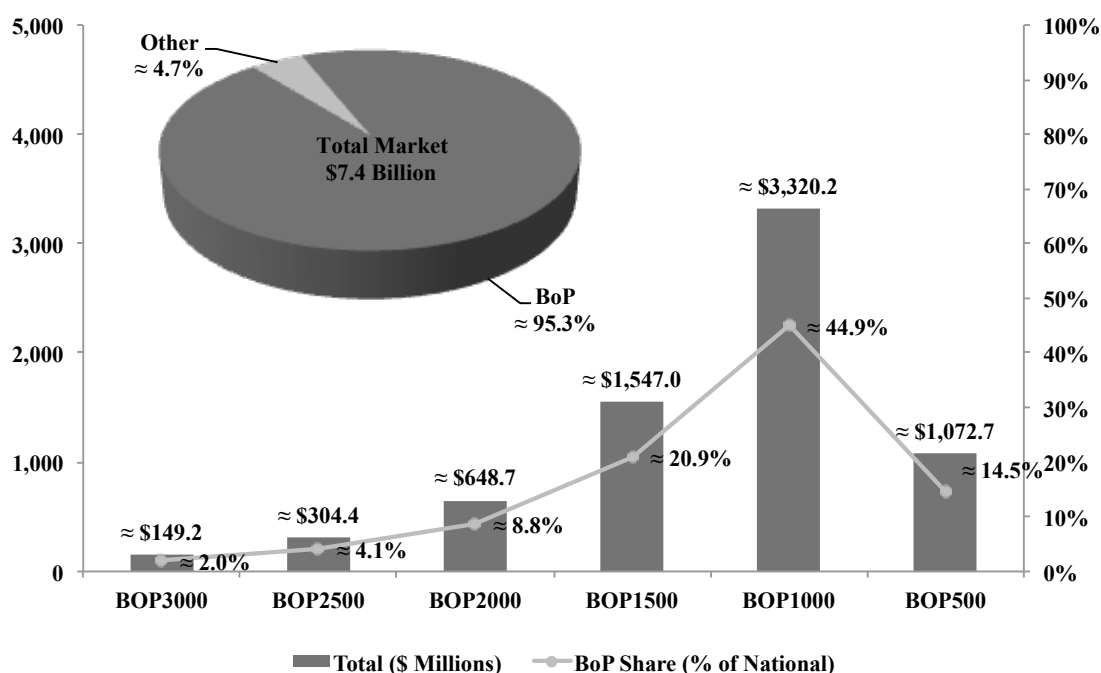


Figure 2.18: Afghanistan (Estimated) – Composition of the BoP Market (SOURCE: Author)

If the percentage of the Afghanistan BoP market relative to total market size is similar to the average for the five-country group, then it may account for roughly 95% of aggregate household spending in the country. In addition, if the average for the five-country group is indicative of the Afghanistan BoP market, then spending is not likely to be distributed evenly across the six segments. Due to a lack of segment data on the Afghanistan BoP market, it is helpful to look at the average distribution of spending within the five-country group to estimate segmentation of the Afghanistan BoP market. This is illustrated in the figure below.

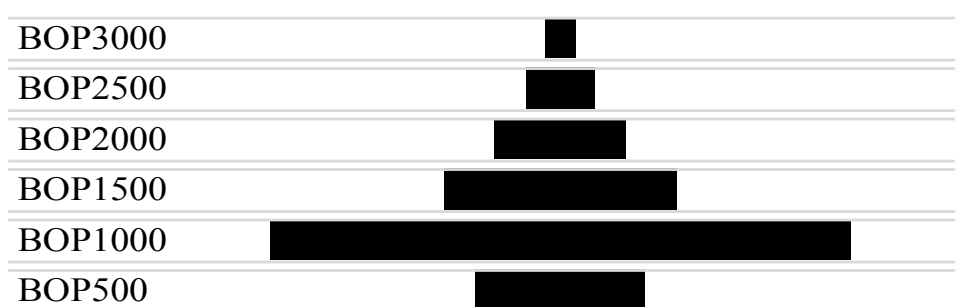


Figure 2.19: Estimated Afghanistan BoP Market by Expenditure (SOURCE: Author)

Although the ANDS report gives a broad number for the total percentage of the population living in rural areas, there is no segment data available for population or spending in Afghanistan (Islamic Republic of Afghanistan, 2013). Therefore, average percentage of spending by segment among the five-country group in urban versus rural areas within the BoP market is used to estimate the data. The estimated share of

spending within the BoP market in Afghanistan in urban versus rural areas by segment is illustrated below.

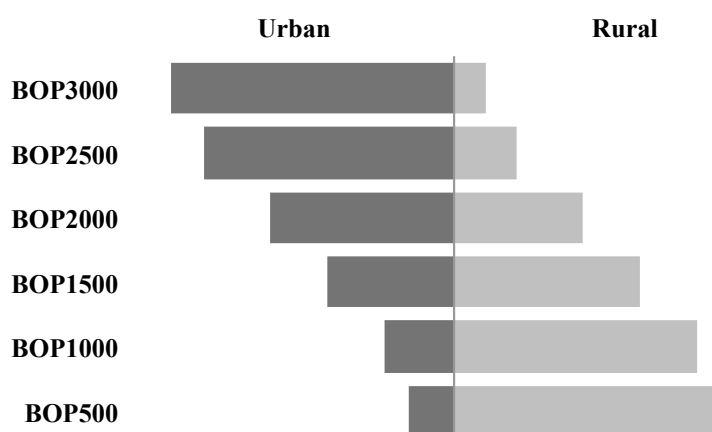


Figure 2.20: BoP Market (Afghanistan) – Estimated Urban/Rural Spending (SOURCE: Author)

The exact structure of the Afghanistan BoP market in regard to distribution of spending across the six segments and share of spending in urban and rural areas is not known. However, given Afghanistan’s small aggregate market size relative to total population and its large rural population, it is likely that the Afghanistan BoP market is similar in structure to the five-country group as explained above. Therefore, it is probable that the Afghanistan BoP market is both bottom heavy and rural.

In summary, BoP market segmentation by income, region and country has been explored in the preceding sections. Income segmentation breaks down the BoP market into six segments and makes it possible to identify characteristics among the various segments. Further, evaluating the BoP market by region and nation is imperative for understanding and estimating the BoP market in Afghanistan, which is the national context of the research study. Subsequently, it is important to limit the focus more narrowly to the health sector within the BoP market because the context of the current study is based on assessment of a BoP venture in the health sector.

2.2.4 BoP Health Sector

The WRI-IFC study provides details concerning several sectors such as food, water, housing, energy and health (Hammond et al., 2007). The various sectors covered by the study range widely in size and composition. Analysing the BoP market by sector provides a clearer picture of market structure and spending patterns within individual sectors. Therefore, the BoP health sector is explored in the following sections. Further, sector data from a multi-country group is used to estimate the composition of BoP health market in Afghanistan and provide context for the current research study.

2.2.4.1 Market Size

The total estimated size of the BoP health market in countries surveyed by the WRI-IFC study is \$158.4 billion. This accounts for the health spending of 3.96 billion people. Regionally, Asia (including the Middle East) has by far the largest share of health spending followed by Latin America, Eastern Europe and Africa (Hammond et al., 2007). The total size of the BoP health market including regional share is illustrated in the following figure.

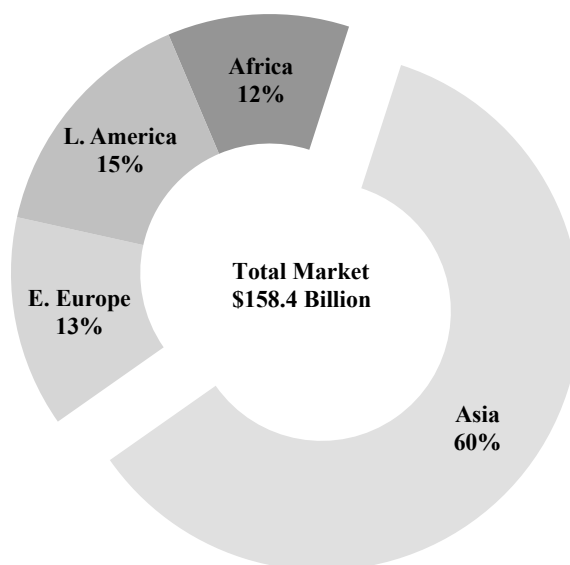


Figure 2.21: Aggregate Size and Regional Share of the BoP Health Market (SOURCE: Hammond et al., 2007)

Not only does Asia have the largest regional health market in absolute terms, but the BoP health market in Asia also accounts for the largest share of the overall health market compared to other regions. For example, the total size of the Asia BoP health market is \$95.5 billion, which is the largest compared to other regions. Further, the Asia BoP health market accounts for 85% of total household health spending in that region while the Africa, Eastern Europe and Latin America BoP health markets account for 54%, 45% and 38% of total regional household health spending, respectively (Hammond et al., 2007). The size of the BoP health market by region along with the share of overall household health spending represented by the BoP market in each respective region is illustrated below.

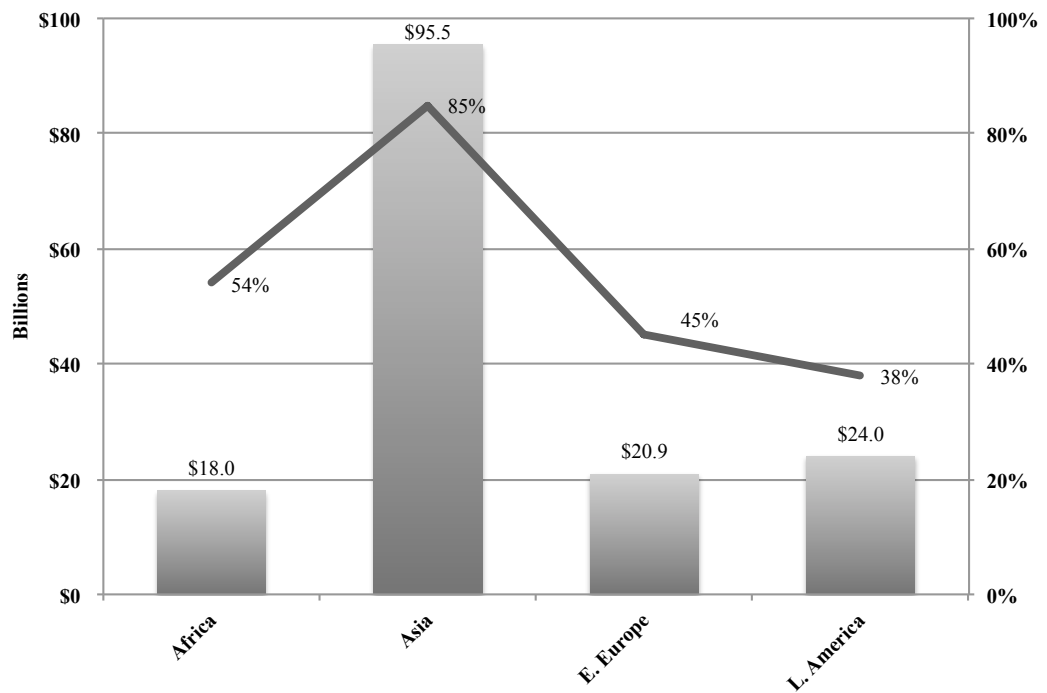


Figure 2.22: Regional Size of the BoP Market & Share of Total Health Spending (SOURCE: Hammond et al., 2007)

As can be seen in the figure above, the share of total household health spending represented by the BoP market differs regionally. This indicates that the importance of the BoP market relative to the total health market varies widely. In Asia, the BoP health market accounts for the vast majority of health spending in that region. Therefore, targeting the BoP health market is very important for organisations participating in the health sector. Conversely, the Latin America BoP health market accounts for only 38% of total health spending, and as a result, it is not as important for health sector players to target this market compared to Asia. Middle and high-income groups comprise the majority of health spending in Latin America, so they represent a more attractive market opportunity in that region (Hammond et al., 2007).

2.2.4.2 BoP Health Sector Composition by Country

Consistent with the preceding country analysis, it is important to examine the composition of the BoP health sector within the same group of countries in the Asia region. However, India is excluded as discussed earlier, and no health sector data is available for Uzbekistan. Therefore, data is used from the four-country group including Bangladesh, Nepal, Pakistan and Tajikistan. Evaluating the health sector in these countries is relevant for understanding and estimating the possible composition of the Afghanistan BoP health sector.

The size of the BoP health market in the four-country group ranges from only about \$120 million in Tajikistan to approximately \$3.7 billion in Pakistan. The percentage of total household health spending represented by the BoP market ranges from approximately 94% in Nepal to nearly 100% in Pakistan (Hammond et al., 2007). The following chart depicts the size of the BoP health market across the four-country group as well as the percentage of the total health market represented by the BoP market in each country.

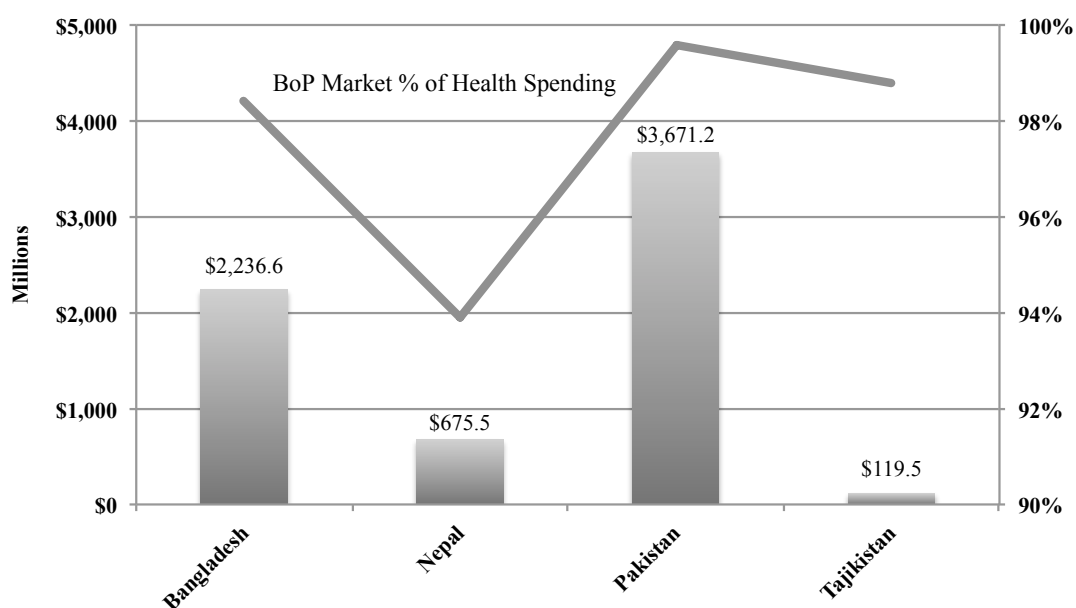


Figure 2.23: Total BoP Health Market (SOURCE: Hammond et al., 2007)

Health sector spending across the four-country group is also highly rural. For example, 75% of spending in Bangladesh, 83% of spending in Nepal, 70% of spending in Pakistan and 68% of spending in Tajikistan occurs in rural areas. This represents the vast majority of health sector spending in each country. The breakdown of urban versus rural health sector spending is illustrated in the following figure (Hammond et al., 2007).

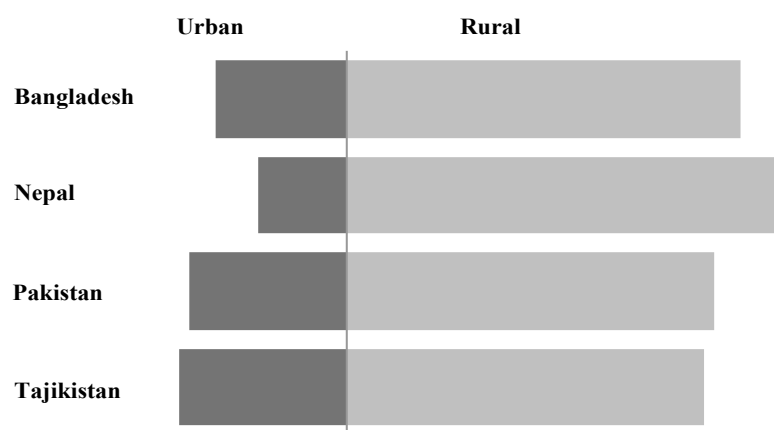


Figure 2.24: Urban vs. Rural Health Sector Spending by Country (SOURCE: Hammond et al., 2007)

Spending on health in each country can be broken down further by income segmentation. Using the six income segments – BOP500, BOP1000, BOP1500, BOP2000, BOP2500 and BOP3000 – health spending can be compared across the various segments. In addition, health spending can be analysed on a per capita and per household basis, which is considered in the following section.

2.2.4.3 BoP Health Sector Spending by Income Segment

Analysing BoP health sector spending by income segment provides a more detailed look at the health sector across the four-country group beyond merely examining aggregate market size. Evaluating segment data is also beneficial for more accurately estimating the Afghanistan BoP health sector. Because aggregate market size varies widely among the four-country group, the relative size of each income segment as a percentage of the total health market in each country is used instead of absolute dollar values to illustrate spending by income segment in the following chart. This results in a more accurate comparison across the four-country group regarding health sector spending by income segment.

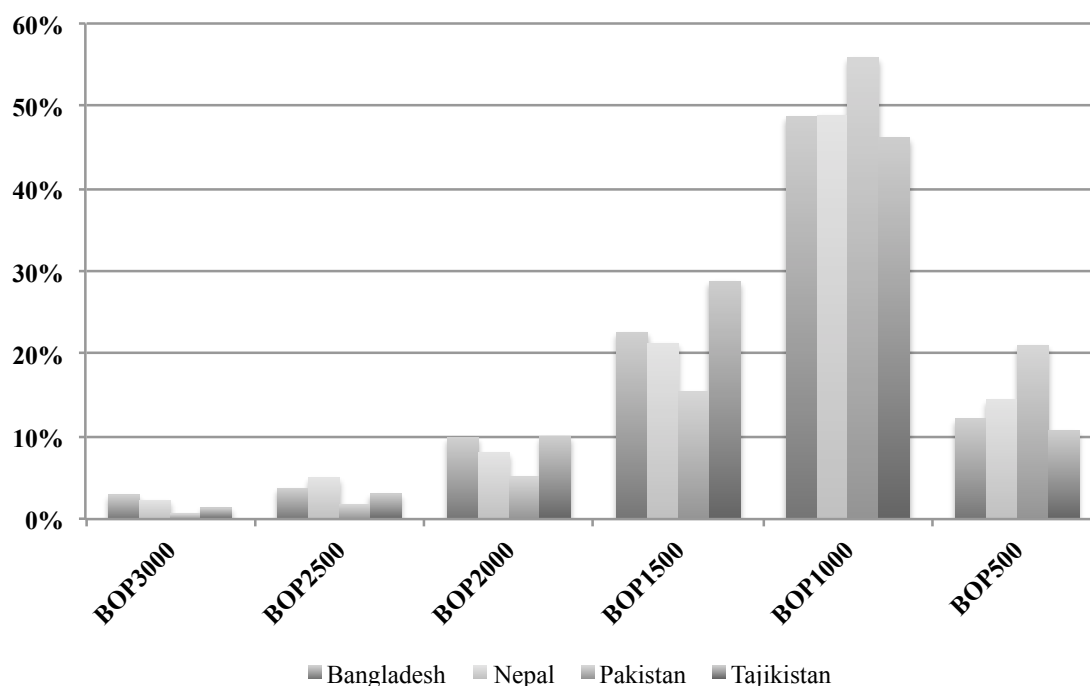


Figure 2.25: Health Sector Spending by Income Segment (SOURCE: Hammond et al., 2007)

The chart illustrates a clear pattern regarding health sector spending by income segment across the four-country group. The BOP1000 segment accounts for the greatest share of health sector spending compared to the other segments in all four countries and ranges from 46.1% in Tajikistan to 55.9% in Pakistan. The BOP1500 segment accounts for the second greatest share of health sector spending in Bangladesh, Nepal and Tajikistan. In Pakistan, the BOP500 segment represents the second greatest share of health sector spending. Likewise, the BOP500 segment accounts for the third greatest share of health sector spending in every country except Pakistan. The BOP1500 represents the third greatest share of health sector spending in Pakistan. Therefore, it is clear that health sector spending across the four-country group is bottom heavy such that the bottom three segments account for 83.4% in Bangladesh, 84.6% in Nepal, 92.4% in Pakistan and 85.6% in Tajikistan (Hammond et al., 2007).

Although total share of health sector spending for the four-country group is bottom heavy, the inverse is true when it comes to per capita and per household spending. For example, health sector spending on a per capita basis in the BOP3000 segment is 7.3 times greater in Bangladesh, 5.3 times greater in Nepal, 3.5 times greater in Pakistan and 6.1 times greater in Tajikistan when compared to the BOP500 segment in each country. The following two figures depict health spending per capita and health spending per household, respectively (Hammond et al., 2007).

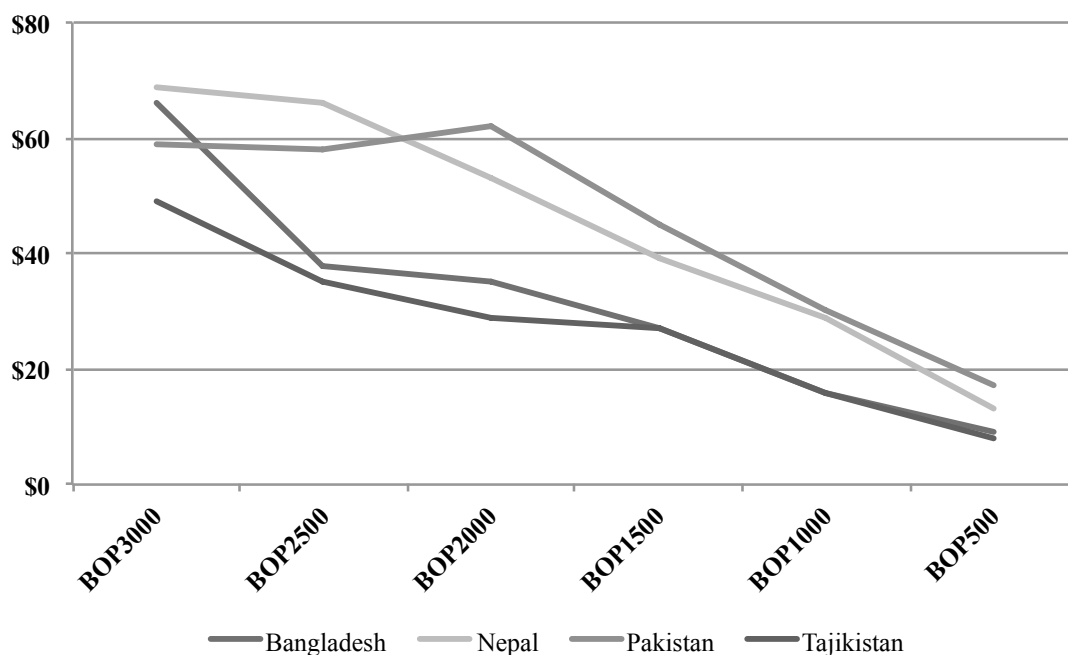


Figure 2.26: Health Sector Spending Per Capita (SOURCE: Hammond et al., 2007)

On a per household basis, health sector spending in the BOP3000 segment is 6.8 times greater in Bangladesh, 3.6 times greater in Nepal, 1.8 times greater in Pakistan and 2.1 times greater in Tajikistan when compared to the BOP500 segment in each country (Hammond et al., 2007).

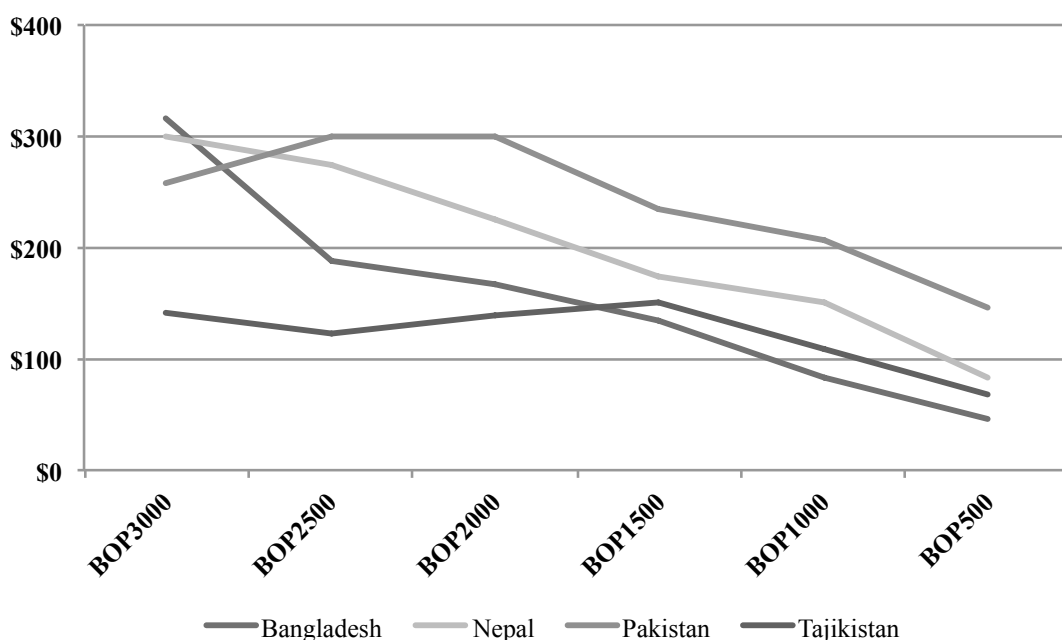


Figure 2.27: Health Sector Spending Per Household (SOURCE: Hammond et al., 2007)

The contrasting picture between the total share of health sector spending across the six income segments and the per capita and per family share of health sector spending across the same segments is indicative of the population concentration in the

bottom three income segments of the BoP health sector across the four-country group. Organisations targeting the BoP health sector in the abovementioned countries should pay attention to these sector dynamics. Although there is a substantial opportunity now to reach the bottom three segments of the BoP health sector, incomes may rise over time. Therefore, whereas the largest market opportunity is currently in the lowest three segments of the BoP health sector across the four-country group, this could change over time. BoP ventures should monitor income growth and consider how higher incomes may impact their business model in the future. For example, BoP ventures may be able to expand services and increase prices over time as per capita and per family health spending increases due to rising incomes.

Further, it is important to evaluate the composition of the Afghanistan BoP health sector in order to provide context for the research study. The BoP health sector in Afghanistan can be estimated using data from the multi-country analysis as well as additional external sources. As previously mentioned, India is excluded because it consistently varies from the average of the six-country group provided in the earlier analysis, and no health data was available for Uzbekistan. Therefore, data from the four-country group, in conjunction with additional external sources, is used to approximate the Afghanistan BoP health sector.

2.2.4.4 Afghanistan BoP Health Sector (Estimated)

It is not possible to determine the structure of the Afghanistan BoP health sector exactly because there is no household survey data available for the country, and Afghanistan was not included in the WRI-IFC study. However, the structure of the Afghanistan BoP health sector can be estimated using comparative data from the previous multi-country analysis as well as additional external sources. Because India and Uzbekistan are excluded, averages from the four-country group are used to estimate the structure of the Afghanistan BoP health sector. Further, data from external sources is used from the 2003-2006 time period when it is available because national expenditure data from the WRI-IFC study was collected from surveys that were standardised as a part of the 2003-2006 round of the International Comparison Programme. As a result, the following analysis provides a general picture of what the structure of the Afghanistan BoP health sector might look like based on averages from similar surrounding countries as well as additional country-level data on Afghanistan.

Gross Domestic Product (GDP) data for Afghanistan, along with average health spending for the country as a percentage of GDP, is used to estimate the size of the BoP

health market in Afghanistan. GDP data is included from 2006 to remain consistent with the WRI-IFC study. Afghanistan's GDP was approximately \$7.1 billion in 2006, and aggregate health expenditures were 6.45% of GDP that same year (The World Bank, 2013a). Therefore, the total health market in Afghanistan in 2006 can be estimated at approximately \$458 million. Further, the percentage of total household health spending represented by the BoP market for Bangladesh, Nepal, Pakistan and Tajikistan is 98.4%, 93.9%, 99.6% and 98.8%, respectively (Hammond et al., 2007). Therefore, the estimated percentage of total household health spending represented by the BoP market in Afghanistan is 97.7 %, and the corresponding size of the Afghanistan BoP health market would be approximately \$447.5 million.

Although the total market size of the BoP health sector can be reasonably estimated using external data, there is no segment data available (BOP3000, BOP2500, BOP2000, etc.). Therefore, average percentages of health sector expenditures represented by each segment for the four-country group are used. For example, the average percentage of total health sector spending for the BOP3000 among the five countries is 1.8% while the average for the BOP500 is 14.6% (Hammond et al., 2007). These percentages are used to estimate the breakdown of the aggregate \$447.5 million BoP health market into the six income segments. The following figure shows the size of the estimated BoP health market and breakdown of BoP health sector spending in Afghanistan by income segment.

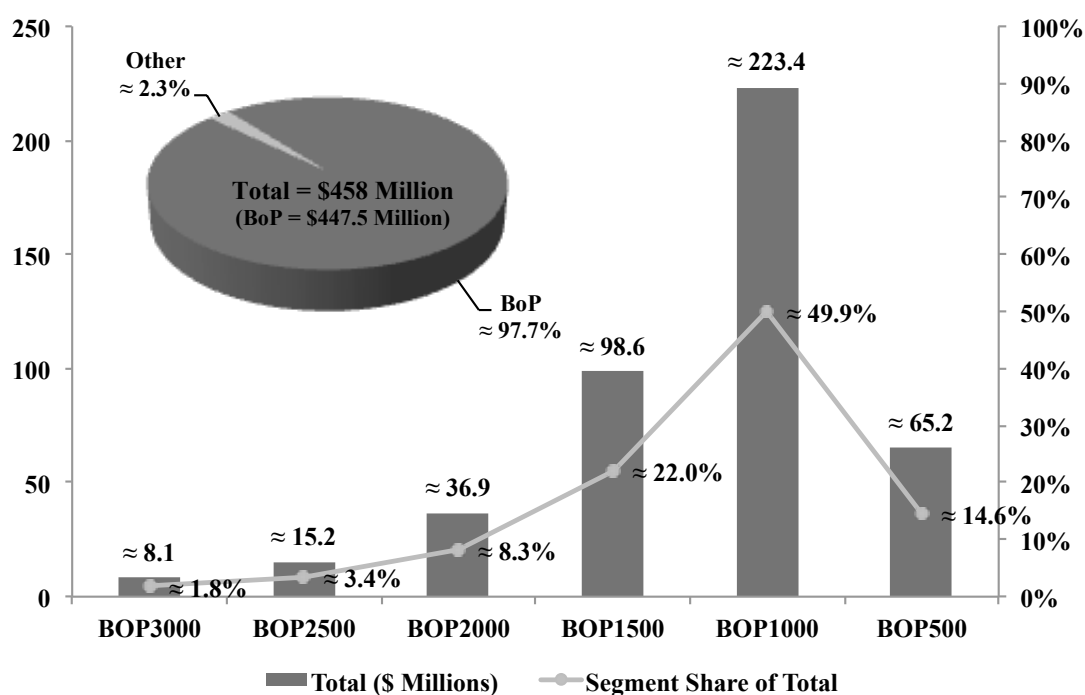


Figure 2.28: Afghanistan (Estimated) – Composition of BoP Health Sector (SOURCE: Author)

According to the 2006 Afghanistan Health Survey (AHS), the median annual per capita spending on health is \$14, and the mean annual per capita spending on health is \$36. With an average household size of approximately seven people, this means the median annual per household spending on health is roughly \$98 while the mean is \$252 (Afghanistan Ministry of Public Health, 2006). As has been mentioned, there is no segment data for Afghanistan. Therefore, averages from the four-country group are used to estimate per capita and per household segment data.

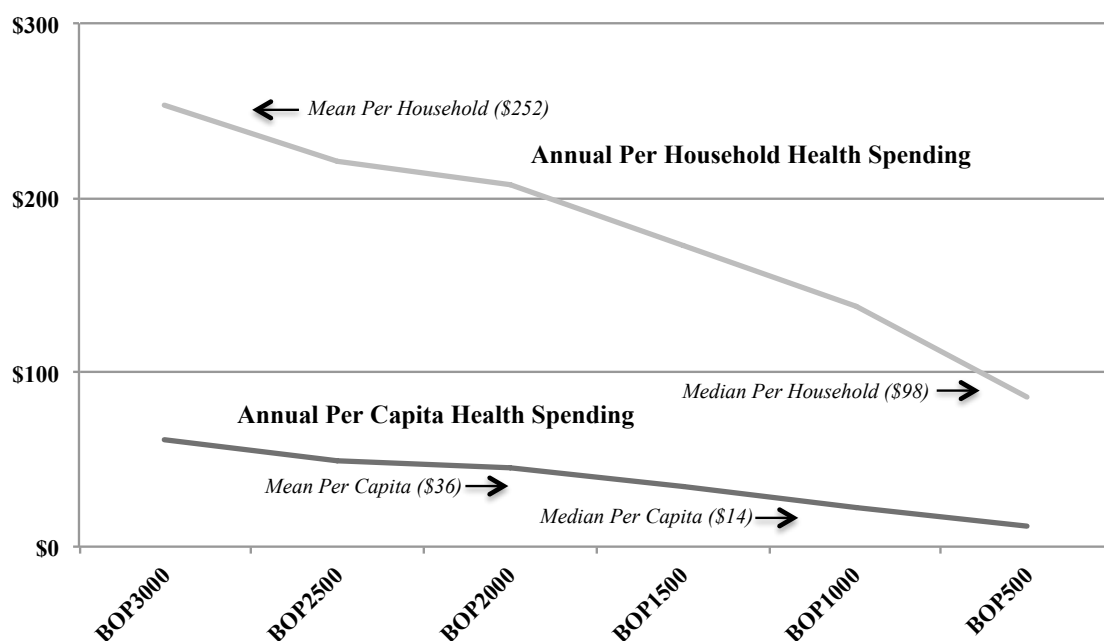


Figure 2.29: Afghanistan (Estimated) – Health Sector Spending by Income Segment (SOURCE: Author)

Given the differences between the mean and median per capita and per household expenditures on health highlighted by the 2006 Afghanistan Health Survey, it is likely that Afghans in higher income segments are spending greater amounts of money on health care on a per capita and per household basis. If this is the case, the average data from the four-country group would support this trend. For example, health sector spending on a per capita basis in the BOP3000 segment is 7.3 times greater in Bangladesh, 5.3 times greater in Nepal, 3.5 times greater in Pakistan and 6.1 times greater in Tajikistan when compared to the BOP500 segment in each country (Hammond et al., 2007). Using the average from the four-country group, the estimated health sector spending on a per capita basis in the BOP3000 segment would be 5.2 times greater compared to the BOP500 segment in Afghanistan.

On a per household basis, health sector spending in the BOP3000 segment is 6.8 times greater in Bangladesh, 3.6 times greater in Nepal, 1.8 times greater in Pakistan and 2.1 times greater in Tajikistan when compared to the BOP500 segment in each

country (Hammond et al., 2007). Based on the average from the four-country group, health sector spending in Afghanistan on a per household basis in the BOP3000 segment would be approximately 2.95 times greater compared to the BOP500 segment. However, as mentioned above, the per capita and per household numbers are only estimates because there is no segment data available for Afghanistan.

As has been discussed previously, Afghanistan is a highly rural society. Approximately 80% of the population lives in rural areas, and it is the rural population that represents the majority of the poor in Afghanistan (Islamic Republic of Afghanistan, 2013). Therefore, it is likely that health sector spending in Afghanistan is highly rural. This is also in line with health sector spending across the four-country group. On average, 74% of BoP health sector spending among the four-country group occurs in rural areas. Therefore, it is reasonable to assume that this average is indicative of health sector spending in Afghanistan. Estimated urban versus rural health sector spending in Afghanistan is presented in the following figure.

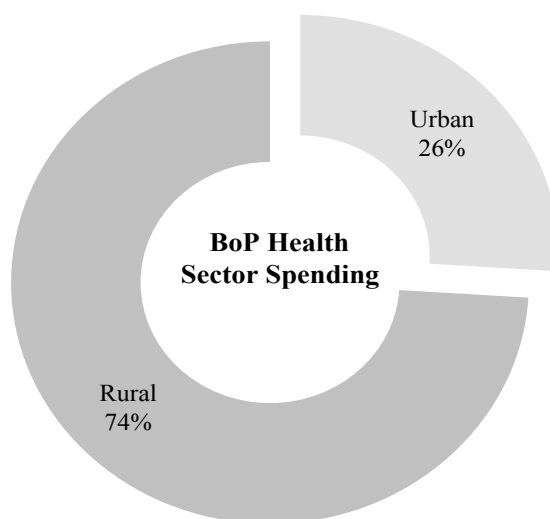


Figure 2.30: Afghanistan (Estimated) – Urban/Rural BoP Health Sector Spending (SOURCE: Author)

Overall, there are several characteristics of the Afghanistan health sector that can be gleaned from this analysis. First, the market size of the BoP health sector is fairly large, which means there is a viable health market in Afghanistan. Second, the BoP health sector is likely bottom heavy with the three bottom income segments accounting for at least three-quarters or more of overall health spending. Third, BoP health sector spending on a per capita and per household basis is expected to be much greater in the upper income segments. This stands in contrast to the concentration of BoP health sector spending in the bottom three segments. Thus, although the market is bottom heavy, health spending on a per capita and per household basis is conceivably greater in the top three segments. Finally, most Afghans live in rural parts of the country, and it is

probable that the majority of BoP health sector spending occurs in the rural areas of Afghanistan.

2.2.5 Segmentation Summary

The preceding market segmentation analysis assesses segmentation by income, region, country and sector. Income segmentation reveals six different income segments – BOP500, BOP1000, BOP1500, BOP2000, BOP2500 and BOP3000 – through which living standard characteristics can be understood. Income segmentation also provides the focal point for further segmenting the BoP market by region, country and sector.

Regional segmentation is included because the research study takes place in Afghanistan, which is part of Central Asia, and the BoP market in the Asia region differs in various ways from other regions such as Eastern Europe or Latin America. Further, close analysis of the BoP market in Asia provides a starting point for understanding BoP market composition in Afghanistan. Although assessing segmentation at the regional level is important, more detail is needed to understand the Afghanistan BoP market. Therefore, segmentation by country is investigated.

Because no country-level data is available concerning the BoP market in Afghanistan, the BoP market in several surrounding nations is explored. In particular, the countries of Bangladesh, India, Nepal, Pakistan, Tajikistan and Uzbekistan are included because they are the nations included in the WRI-IFC study that are closest in proximity and culture to Afghanistan. BoP market segmentation within these nations has provided a baseline for estimating and understanding the Afghanistan BoP market. Finally, segmentation by sector has provided an estimate of what the Afghanistan BoP health sector might look like based on data from a four-country group (Bangladesh, Nepal, Pakistan and Tajikistan) as well as additional country data on Afghanistan.

Consequently, market segmentation has developed context for the research study by estimating both the country-level BoP market as well as the BoP health sector in Afghanistan. As a result, the reader is able to understand probable composition of each including parameters such as market size, segmentation and spending patterns. However, to better understand how impact might be measured in the health sector in Afghanistan, a more complete description of health care in Afghanistan is needed. This is necessary because the dynamics of the health care sector in Afghanistan are unique and still in the developmental stages due to ongoing reconstruction of the country. Therefore, the following section provides an in-depth evaluation of health care in Afghanistan.

2.3 HEALTH CARE IN AFGHANISTAN

As mentioned above, it is important to assess what is known about health care in Afghanistan in order to understand the context for the research study. Market size, segmentation and spending patterns within the BoP health sector in Afghanistan were estimated in the preceding analysis. However, it is essential to take a more in-depth look at the background and current state of health care in Afghanistan. Further, to grasp how health care is delivered in the country, it is helpful to break down the overall health sector in Afghanistan into two sub-sectors – the public health sector and private health sector. Therefore, the development and operation of the public and private health sectors, as well as the relationship between the two interrelated sectors, are assessed in the following sections.

2.3.1 Background

Following almost three decades of war, the entire country of Afghanistan, the government, infrastructure and health sector were all but destroyed. The conflict began with the Communist takeover in the late 1970s, and the 10-year invasion and war lasted from 1979 to 1989. Communist rule left Afghanistan economically undeveloped and politically divided. Although the Afghan resistance to Soviet occupation ultimately led to freedom from Soviet rule, the country remained torn by years of subsequent conflicts and injustice (Coleman, 2013; Islamic Republic of Afghanistan, 2008b).

During the Soviet war in Afghanistan, the West aided Mujahedeen resistance fighters to oust Soviet forces. However, once Soviet forces withdrew from the country, Western interest and support faded. Shortly thereafter, internal factions fought for control in a devastating civil war. The war resulted in the destruction of much of Afghanistan's infrastructure, including what limited health care facilities existed in the country (Acerra et al., 2009; CIA, 2013; Coleman, 2013).

The Taliban then took control and dominated the political landscape starting in 1996. As a result of their rule, the Taliban moved Afghanistan backwards politically, economically and culturally. The successive wars killed over a million Afghans, forced several million people into exile and refugee camps and left almost a million people disabled. The destruction of core institutions and a war torn economy led to extreme levels of poverty, illiteracy, gender inequality and a degenerated health care system (CIA, 2013; Coleman, 2013; Islamic Republic of Afghanistan, 2008b; Islamic Republic of Afghanistan, 2013).

As a result of decades of war, Afghanistan was left with some of the worst health statistics in the world, especially in regard to women and children. For example, the infant mortality rate was estimated at 165 deaths per 1,000 live births, and the under-five infant mortality rate was estimated at 257 deaths per 1,000 live births. The under-five infant mortality rate ranked among the third or fourth highest in the world. Maternal mortality rate was estimated between 1,600 and 2,200 deaths per 100,000 live births, which means that the lifetime risk of maternal death in Afghanistan was approximately one in six to one in nine. Mortality rates varied regionally across Afghanistan with some regions reporting higher rates than others. In at least one mountainous region of the country, maternal mortality was found to be 6,507 deaths per 100,000 live births, which was the highest rate ever reported. Further, average life expectancy was estimated at only 42.6 years of age in Afghanistan (Bartlett et al., 2005; Strong et al., 2005; UNICEF, 2004, 2007; Waldman and Hanif, 2002).

During the 1980s and 1990s, the majority of health care in Afghanistan was provided by NGOs that worked cross-border from Pakistan. The NGOs normally provided good services and were funded internationally by external sources. However, health care coverage was limited such that there was an average of one health facility per population of 50,000 people. During this time, the quasi-governments in power in Afghanistan did not have the ability or intention to coordinate the health care activities of the NGOs. Likewise, the NGOs were reluctant to work closely with, or submit to, the supervision of these quasi-governments that were not generally recognised internationally and were known to commit human rights abuses. Therefore, there was no central health care policy, and the provision of primary health care services was extremely limited and unevenly distributed throughout the country (Loevinsohn and Sayed, 2008; Waldman et al., 2006).

This was the context in which the international community entered Afghanistan after the Taliban was driven from the country in 2001. After the signing of the Bonn agreement in December of 2001, a transitional government was put in place, and the Afghan Ministry of Public Health (MoPH) was sanctioned to develop health care policy for Afghanistan. The MoPH was immediately confronted with the fragmented and uncoordinated health care system. Therefore, an advisory committee to the MoPH was formed consisting of representatives from the World Health Organisation (WHO), United Nations Children's Fund (UNICEF), United Nations Fund for Population Activities (UNFPA), Management Sciences for Health (MSH) and local NGO

community (CIA, 2013; Coleman, 2013; Loevinsohn and Sayed, 2008; Strong et al., 2005; Waldman and Hanif, 2002).

In cooperation with the advisory committee, the MoPH began to define essential health care services that should be made available throughout the public health care system in Afghanistan. The collaborative work by this team of individuals resulted in creation of the Basic Package of Health Services (BPHS). The BPHS forms the foundation of public health care policy in Afghanistan (Loevinsohn and Sayed, 2008; Transitional Islamic Government of Afghanistan, 2003; Waldman and Hanif, 2002).

2.3.2 Public Health Care

2.3.2.1 Establishment of the Public Health Care Sector

The MoPH began the process of establishing the country's major health care priorities in 2002. To rebuild the national health system, the MoPH had to determine which health services were essential to address the most serious health issues facing the country. The MoPH decided that the services included should have the greatest impact on the major health problems, should be cost-effective in addressing the majority of health problems and should provide equal access to urban and rural Afghans. These services are known as the Basic Package of Health Services (BPHS) and represent the official health care policy of the Islamic Republic of Afghanistan (Transitional Islamic Government of Afghanistan, 2003).

The BPHS has a dual purpose. First, it exists to provide a standardised package of basic services to be provided in all primary health care facilities in Afghanistan. Second, the BPHS promotes equitable access to health care services, especially for underserved areas of the country. Services initially incorporated in the BPHS include maternal and newborn health, child health and immunisation, public nutrition, communicable diseases, mental health, disability and supply of essential pharmaceuticals. In the first draft of the BPHS, four types of facilities were included within the public health care sector – Health Post (HP), Basic Health Centre (BHC), Comprehensive Health Centre (CHC) and District Hospital (DH) (Transitional Islamic Government of Afghanistan, 2003).

Modifications were made to the original BPHS in 2005 and 2010. Principal changes made in 2005 included elevating the importance of services regarding mental health and disabilities. Several other minor changes were incorporated such as fully defining the job description of a community health worker (CHW) and increasing staffing requirements at the various types of facilities (Islamic Republic of Afghanistan,

2005a). Also, in 2005, the MoPH completed an Essential Package of Hospital Services (EPHS) to complement the BPHS. The EPHS established three levels of hospitals – District Hospital (DH), Provincial Hospital (PH), and Regional Hospital (RH). For each level of hospital, the EPHS identified the services to be provided, diagnostic services available, equipment necessary to provide services in the hospital, pharmaceutical supplies and minimum staffing requirements (Islamic Republic of Afghanistan, 2005b).

Later, in 2010, changes to the BPHS were made a second time, which included the introduction of primary eye care and an expansion of the essential pharmaceutical supply. In addition, two new categories of health facilities were created – Health Sub-Centres (HSC) and Mobile Health Teams (MHT). The 2010 revision of the BPHS also further explained the relationship between the BPHS and EPHS (Islamic Republic of Afghanistan, 2010a).

2.3.2.2 Organisation of the Public Health Care Sector

As explained above, the public health care sector in Afghanistan is categorised into two complementary systems – BPHS and EPHS. Primary care services are provided within the BPHS by the Health Posts, Health Sub-Centres, Mobile Health Teams and Basic Health Centres. Secondary care services are provided within the BPHS by the Comprehensive Health Centres and District Hospitals. Tertiary care services are provided within the EPHS by the Provincial Hospitals and Regional Hospitals (Islamic Republic of Afghanistan, 2010a).

The foundation of the BPHS starts at the community level with the community health worker. CHWs are trained community volunteers who provide basic health services from their own homes, which function as Health Posts. A Health Post is typically staffed by one male and one female who both live in the community. The HP is designed to serve a population of between 1,000-1,500 people, which is equivalent to approximately 100-150 families. CHWs can provide limited curative care for ailments including respiratory infections, diarrhea and malaria. They are also equipped to provide contraceptives and counseling regarding supplements and nutrition (Islamic Republic of Afghanistan, 2010a).

When a CHW cannot properly diagnose a health condition or the condition is more serious than he or she is equipped to handle, the patient is normally referred to a Basic Health Centre. However, if a BHC is not available within the region, the individual is referred to a Health Sub-Centre or a Mobile Health Team may make a routine visit to the patient's village. HSCs and MHTs were new additions to the BPHS

in 2010 because BHCs did not adequately cover the sparse rural population scattered across the mountainous countryside, and many regions in Afghanistan lack basic infrastructure such as roads and bridges (Islamic Republic of Afghanistan, 2010a).

Therefore, the objective of integrating HSCs and MHTs into the BPHS was to provide health services for underserved pockets of Afghans living in remote areas of the country. The HSC is able to serve a population of between 3,000-7,000 people whereas the MHT travels to less populated areas. HSCs and MHTs provide a wider range of health services than the HPs and include services such as immunisation, antenatal care and family planning. They are also equipped to treat infectious diseases including diarrhea and pneumonia. When HSCs or MHTs encounter severe cases, patients are referred to higher-level facilities such as the Basic Health Centre (Islamic Republic of Afghanistan, 2010a).

The Basic Health Centre is the standard clinic in Afghanistan. It not only reaches a larger population than the HP, HSC or MHT, but it also provides a much wider range of health care services than the lower-level facilities. The BHC is able to serve a population of between 15,000-30,000 people. BHCs provide outpatient care, immunisations, maternal care and newborn care. Maternal care offered by BHCs includes antenatal care, delivery and postpartum care. BHCs also provide contraceptives and treat ailments such as malaria, pneumonia, tuberculosis, mental illness and disabilities. Cases that BHCs are unable to handle are referred to higher-level facilities such as Comprehensive Health Centres or District Hospitals (Islamic Republic of Afghanistan, 2010a).

Comprehensive Health Centres reach an even larger population than Basic Health Centres, between 30,000-60,000 people, and provide a wider range of health services as well. For example, CHCs are equipped to handle complicated cases regarding delivery, grave illnesses, severe cases of malaria and outpatient care for mental health patients. CHCs have a laboratory and some limited space for inpatient care. Patients with disabilities and those requiring physiotherapy can be screened and referred to appropriate specialised facilities. When CHCs face the most complicated cases such as those requiring emergency services or surgery, patients are referred to district hospitals (Islamic Republic of Afghanistan, 2010a).

District Hospitals handle all services included in the BPHS, but also incorporate services such as emergency care (including obstetrics), surgery, anaesthesia and X-rays. Compared to CHCs, a wider range of pharmaceuticals and laboratory services are provided at DHs. The DHs provide both outpatient and inpatient services, and mental

health services and physiotherapy are also offered. Each DH serves between 100,00-300,000 people (Islamic Republic of Afghanistan, 2010a).

The District Hospital is the link between the BPHS and EPHS. The BPHS and EPHS are complementary structures that provide a two-way referral system such that patients needing more critical care are referred to the EPHS system and patients that have stabilised can be referred back to the BPHS system. Therefore, the DH is the linchpin between the two systems. In the EPHS system, the Provincial Hospital is the first referral hospital from the DH. The PH provides essentially the same services as the DH, but the PH is much larger. For example, DHs have between 25-75 beds whereas PHs have between 75-250 beds. Further, the PH can refer patients to the Regional Hospital to receive even higher levels of care (Islamic Republic of Afghanistan, 2005b; Islamic Republic of Afghanistan, 2010a).

The Regional Hospital is the final facility within the EPHS and functions mainly as a referral hospital with several specialties (ENT, ophthalmology, etc.) for assessing, diagnosing and treating or referring back to a lower-level hospital. It is by far the largest health facility with 300-450 beds with the most specialised doctors and equipment. The RH also plays an integral role in the training of medical professionals and conducting and collecting health system research. The following figure illustrates how the BPHS and EPHS operate and are linked by the DH (Islamic Republic of Afghanistan, 2005b; Islamic Republic of Afghanistan, 2010a).

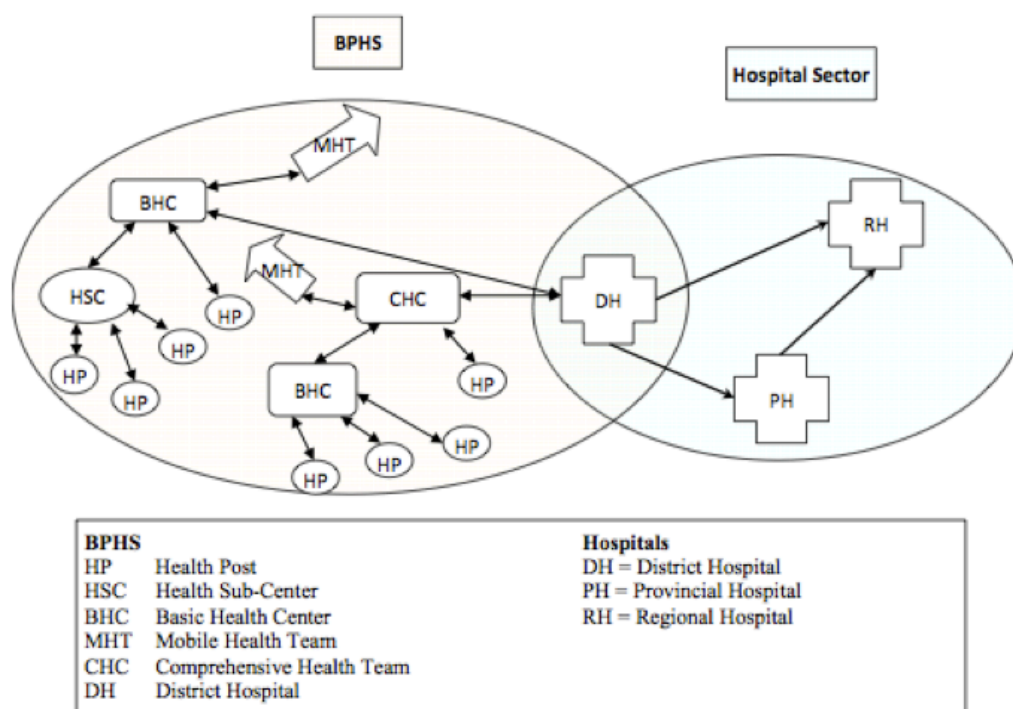


Figure 2.31: Link between the BPHS and EPHS (SOURCE: Islamic Republic of Afghanistan, 2010a)

2.3.2.3 Operation and Funding of the Public Health Care Sector

Although the MoPH was able to initially set up a system for public health care in Afghanistan, it faced several key challenges in regard to implementation. First, the MoPH lacked the experience and capacity necessary to deliver the public health care services. Second, only a feeble network of public facilities existed. Third, the national development budget was insufficient to provide the essential inputs required to fund the services at the national level. NGOs, on the other hand, had already been providing health care services across the country throughout the prolonged wars in Afghanistan and continued to do so during the transition to the newly elected parliament and government in 2002. Therefore, the MoPH decided to contract with NGOs to deliver the public health services across Afghanistan (Newbrander et al., 2011; Sabri et al., 2007).

The MoPH established a bidding process for national and international NGOs to compete for service contracts in specific geographic areas such as a district or province. Winning bidders are authorised to deliver the public health services to a specified geographic region in Afghanistan. The government and donors evaluate performance of the NGOs and repeat the bidding process at the end of the contract period. The major funding agencies – the World Bank, USAID and European Commission – work collaboratively with the MoPH to fund the contracts (Roberts et al., 2008).

Funding of the contracts depends on payments made to the NGOs based upon the number of individuals serviced by the provider. In 2002, the reference cost used to negotiate the delivery of services was \$4.50, but the cost varied from \$3.80 to \$5.10 among donors. Based on these figures, donors allocate funds on a per capita basis (Roberts et al., 2008). A 2010 assessment of the costs associated with providing public health care services within the BPHS revealed the initial estimates were generally accurate. For example, the average per capita cost of providing BPHS services was found to be \$4.17, and the average per capita cost ranged across various provinces from \$2.43 in Ghazni Province to \$5.16 in Takhar Province (Islamic Republic of Afghanistan, 2010b).

Although the MoPH does not actually deliver or fund the services, it plays the central stewardship role. Its responsibilities include reviewing contract bids, evaluating NGO performance, coordinating funding with donor agencies and establishing strategies, standards and regulations for the public health care sector (Ridde, 2005; Roberts et al., 2008). Beginning in 2002, the MoPH entered into contracts with 27 NGOs to provide public health care services in 31 of the 34 provinces in Afghanistan. However, the MoPH chose to retain responsibility for delivery of services in three

provinces (Palmer et al., 2006). This contracting approach allowed the MoPH to scale service delivery throughout the country at a rapid pace. Consequently, the use of contracting resulted in an increase in access to public health services in Afghanistan from 5% in 2002 to 77% in 2006 (Newbrander, 2006; Newbrander et al., 2011).

Contracting has led to greater access and utilisation of health services in Afghanistan (Arur, 2008). However, there is some evidence that inequalities exist in terms of use of service, ease of access to facilities and cost of care (Arur et al., 2010; Trani et al., 2010). In addition, the contracting approach tends to rely heavily upon donors, and direct funding of NGOs by donor agencies can undermine government capacity building. For example, local health offices across Afghanistan often have little capacity because resources flow directly from Kabul to the contracted NGOs (Witter, 2012; Zivetz, 2006).

Questions remain concerning whether the Afghan government will be able to resume providing services directly or whether the contracting approach will become a more permanent feature of public health care services delivery in Afghanistan (Strong et al., 2005). If the latter is the case in Afghanistan, then sustainability is a concern. Thus, the sustainability of the contracting approach in Afghanistan has yet to be proven (Loevinsohn and Harding, 2005). Given that 90% of the aid to the public health sector in Afghanistan comes from foreign assistance, sustainability is a critical long-term issue (Zivetz, 2006).

Thus, utilising a contracting approach for delivering health care services has produced mixed results in Afghanistan. On one hand, contracting has achieved impressive results in improving the availability of services, population-based utilisation rates and some measures of quality (Arur, 2008; Newbrander, 2006). However, dimensions of performance such as equity, quality and efficiency need further assessment. These results are similar for other low-income countries such as Bangladesh, Cambodia and Haiti where the contracting out of health care services has been adopted (Bloom et al., 2006; Liu et al., 2008). Therefore, although the current approach for operating and funding the public health care sector in Afghanistan has achieved some initial success, questions remain regarding its long-term viability.

2.3.3 Private Health Care Sector

2.3.3.1 Overview

Although the government of Afghanistan (in cooperation with the international community) has focused their efforts on creating and organising the public health sector

in Afghanistan, a sizeable private sector has evolved alongside the public sector. The development of the private health sector has been due in part to the lack of coverage and weaknesses in the public sector, which has resulted in the emergence of numerous private sector providers. Although the private health sector is large, attempts at coordination and regulation have been met with limited success (Pavignani and Colombo, 2002; Steinhardt et al., 2009).

There is very limited data on the private health sector in Afghanistan, and evidence concerning this vast grey area is largely anecdotal. Information regarding the private health sector is typically scattered among various reports, often written by NGOs. However, some evidence suggests that the private sector plays a significant role in Afghanistan (Pavignani and Colombo, 2002; Steinhardt et al., 2009). For example, the 2006 Afghanistan Health Survey assessed care seeking practises of Afghans and found that private providers were used more extensively than public health care providers (Afghanistan Ministry of Public Health, 2006). Further, it is estimated that the private health sector accounts for 70-80% of pharmaceuticals consumed in the country (Patterson and Karimi, 2005).

2.3.3.2 Types and Selection of Private Sector Providers

As the private health sector in Afghanistan has developed over time, various types of private health providers have emerged. There are formally established facilities such as hospitals, clinics, pharmacies and laboratories. In addition, many physicians have their own private practices, which may be in a small office or the physician's home. A solo practice may be the physician's only means of practising medicine, or the physician may operate it as a side practice in conjunction with working for another public or private facility. Nurses, midwives and birth attendants also often practise in the private sector. CHWs, who are part of the public health sector, may occasionally sell services and drugs in remote areas. Traditional healers such as Mullahs practise in the private sector as well, but typically rely upon religious or superstitious methods (Alsi et al., 2009; Pavignani and Colombo, 2002).

Among private providers identified by households in the 2008 Afghanistan Private Sector Health Survey (APSHS), the vast majority of those interviewed cited reliance upon a physician with a solo practice – almost 89%. Roughly 4% of respondents cited traditional healers and 3% named pharmacies (with or without practising physician) as the private sector provider they had visited. Approximately 2% of those surveyed identified private health clinics and hospitals as the private sector

provider of choice, and merely 1% identified traditional birth attendants and midwives as the private sector provider family members chose. Less than 1% identified nurses as the private sector provider visited. Overall, physicians with a solo practice are the most widely utilised provider among private sector providers (Alsi et al., 2009). Private physicians with a solo practice were also found to be the most prevalent type of private health sector provider in the 2006 AHS (Afghanistan Ministry of Public Health, 2006).

2.3.3.3 Services Provided within the Private Sector

The services provided by private sector providers tend to be more specialised than in the public sector. The result is that patients seeking care within the private sector face the challenge of obtaining one-stop health care. The problem is exacerbated further due to marginal information and referral systems. Among private health sector providers, the APSHS found general service menus for clusters of related services. The various menus include basic primary health services, enhanced primary health services, basic maternal health services, enhanced maternal and child health services, one-stop prescription and drug service and key public health services (Alsi et al., 2009).

Basic primary health services include services such as routine physical examinations, diagnosis, prescribing medication and antenatal and postnatal care. Enhanced primary health services include basic primary health services plus additional services such as family planning, immunisations, X-ray and tuberculosis and malaria diagnosis and/or treatment. Basic maternal health services include antenatal care, delivery and postnatal care. Enhanced maternal and child health services include basic maternal health services plus healthy family information, family planning and immunisations. One-stop prescription and drug service involves providers who diagnose conditions, prescribe drugs and provide the drugs. Finally, the key public health services menu includes diagnosis and/or treatment of both tuberculosis and malaria (Alsi et al., 2009).

As mentioned, one-stop health care is difficult to obtain for those seeking care by private health sector providers due to the specialised nature of the private sector. For example, whereas 15.5% of private providers surveyed in the APSHS provide basic primary health services, only 0.7% provide enhanced primary health services. Similarly, 24.3% of private providers surveyed provide basic maternal health services whereas only 8.1% provide enhanced maternal and child health services. Further, of the general service menus discussed above, no more than 25% of private sector providers offer any

single menu. As a result of the specialised nature of the private health sector, it is relatively complementary to the public health care sector (Alsi et al., 2009).

2.3.4 Comparison and Performance of the Public and Private Sector

2.3.4.1 Public-Private Overlap

As noted above, there is an overlap between the public and private health sectors in Afghanistan. However, this overlap has not necessarily resulted in significant competition between the two sectors. Data from interviews with private providers in the APSHS suggest that the services provided by the public and private sectors are more complementary than competitive. Consequently, there are different reasons for visits to public and private health clinics, particularly regarding gender and age. The majority of households where children needed routine health care visited providers in the public sector whereas the majority of adults seeking routine care visited providers in the private sector. Similarly, households were more likely to seek care at public sector providers for children's illnesses and injuries compared to adult illnesses and injuries (Alsi et al., 2009). Female-headed households were found to be more likely to visit public providers than male-headed households. In fact, women-headed households were three times less likely to use private providers than male-headed ones (Trani et al., 2010). Consequently, the data suggest that the public health care sector is known more as the provider of maternal and child health services while private sector providers have tended to specialise in adult illnesses and injuries.

Beyond relying upon alternate providers for different health needs, the APSHS further found that the diversity in reliance upon public and private providers varied from province to province. The proportion of households visiting only private providers was the highest in Badghis and Logar (about 73% in each province), and it was the lowest in Baghlan (approximately 36%). The patterns varied for the central and rural districts within the provinces as well. These differences reflect both preferences and accessibility of public and private health care providers. Consequently, location of the public or private health care provider impacted provider choice, specifically in regard to whether or not the provider was located within the village. In addition, location of the provider impacts travel time, and more than three-fourths of visits were to providers less than an hour from the home. As a result, it appears that private providers fill in the gaps where public providers are not available and vice versa. Therefore, the overlap between the public and private health care sector appears to be more of a positive development rather than a systematic problem (Alsi et al., 2009).

2.3.4.2 Utilisation

The public and private health care sectors are relatively complementary, and it appears that utilisation of providers within the two sectors partially reflects this configuration. Several broad-level household surveys exploring utilisation of public and private health care providers were conducted in 2004, 2005, 2006 and 2008. Results from the surveys show that utilisation varies among the provinces and districts. However, aggregate national-level data reveal a generally emerging trend toward utilisation of private sector providers. Consequently, while public sector providers in Afghanistan were the most common type of provider in 2004, the surveys indicate utilisation of private sector providers was generally increasing across Afghanistan from 2004 to 2008. Although the various surveys generally indicate this trend toward utilisation of private sector providers, the samples in each survey were not equally representative of general health care utilisation across all of Afghanistan. In fact, Afghans utilise public sector providers far more than private sector providers in some provinces.

In 2004, the MoPH administered the National Health Services Performance Assessment (NHSPA), which included patient interviews as well as a household survey with questions regarding utilisation of public and private health care services. The NHSPA was conducted from June to October using a stratified random sample of all facilities providing public health care in each of Afghanistan's 33 provinces. The sample included 617 facilities and 5,597 patient interviews. In addition, interviews were conducted with women from 13,843 randomly selected households from a random selection of communities in the catchment area of the clinics. After the NHSPA was completed in 2004, the facility-based patient interviews have been conducted annually. However, the survey was only administered among households in 2004 (Afghanistan Ministry of Public Health, 2004; Peters et al., 2007).

The NHSPA discovered that public health care providers were the most commonly sought source of health care in the country in 2004. Of those surveyed, almost two-thirds of Afghans first sought care from public providers. However, private health care providers were the most commonly visited second providers. Approximately 53% of Afghans relied upon private providers when requiring a second visit to a health provider. Further, although those with children under the age of five years old were more likely to seek care from a public provider, those with children over the age of five were more likely to seek care from a private provider (Afghanistan Ministry of Public Health, 2004; Steinhardt et al., 2009).

Trani et al. (2010) conducted a nationwide survey from December 2004 to August 2005 to investigate provider choice as well as measure associations between perceived availability and usefulness of health care providers in Afghanistan. The multistage cluster sample included 5,130 households and was designed to be representative of all households in Afghanistan. The survey results found that disabled people, female-headed households and the poorest households relied upon public providers more than other groups. However, all groups surveyed collectively used private providers more often than public providers. Additionally, although the poorest households used public providers more frequently than wealthier households, there was a general low-level of overall utilisation among public providers.

Two years after the NHSPA was conducted, the MoPH directed the administration of the 2006 Afghanistan Health Survey. The AHS was a population based survey designed to provide information on health related matters in Afghanistan such as maternal and child health, health care utilisation and health related expenditures. The multi-stage cluster survey involved a sample of 8,278 households and was designed to be representative of most of rural Afghanistan. According to results from the household survey, Afghans used private sector providers more often than those in the public sector. For example, approximately 56% of Afghans sought care at private providers (including traditional healers) versus roughly 44% at public providers for the first provider sought. However, the percentages increase dramatically regarding utilisation of the private health sector when seeking subsequent providers. For the second and third provider, Afghans sought private providers (including traditional healers) approximately 69% and 73% of the time, respectively. Conversely, the percentage of Afghans seeking public providers for the second and third providers dropped to roughly 31% and 27%, respectively (Afghanistan Ministry of Public Health, 2006).

Subsequently, the 2008 APSHS was designed by the Afghanistan Private Sector Survey team to investigate health-related issues raised in the 2006 AHS concerning the private health sector's role in Afghanistan. A random sample of 776 households was chosen from five provinces to account for regional diversity of local health care systems in different rural areas of Afghanistan. Interviews were then conducted with 152 private providers that the households identified. Household utilisation of private and public providers was one of the many topics explored in the study. Overall, the household survey found that the majority of Afghans use private sector providers for their health care needs. When households were asked to give details concerning visits to up to three

individual health providers, 78% identified private health sector providers while only 21.4% identified public health sector providers. Over half of the households surveyed (55.3%) reported visiting private providers exclusively while only about 10% reported exclusively visiting public providers. Approximately one-third of households reported visiting both public and private providers (Alsi et al., 2009).

Among sick adults, 71.4% sought care from a private provider compared to only 28.6% from a public provider. Likewise, 58.6% of households sought care for a sick child from private providers compared to only 41.4% from public providers. In addition, adults more often obtained advice and medicine from the private sector – 65.5% and 81.4%, respectively. Although the survey found that Afghans primarily use private sector providers for all health-related needs, there was one exception. Households with children needing routine health care utilised public providers 81.5% of the time versus only 18.5% for private providers. Overall, the data suggests that although utilisation of private sector providers is broadly increasing, the public and private health sectors are still reasonably complementary (Alsi et al., 2009).

A separate survey involving utilisation was conducted by Cockcroft et al. (2011) during July-August 2008. The survey involved a stratified random sample of 30 communities across two districts in Kabul province (which is not representative of the entire country), and the total sample comprised 3,283 households. The survey compared government operated health facilities against NGO contracted health facilities within the public sector as well as overall public sector providers against private sector providers. The government operates health facilities either directly through the MoPH or through the Strengthening Mechanism (SM) of contracting with Provincial Health Offices. In the SM district, approximately 63% of households reported normally using public sector providers while only 36% of households said they usually visited private sector providers. In the NGO district, more than 93% of households typically visited public sector providers compared to only 5% that normally used private sector providers.

Overall, the various surveys do suggest a growing trend towards greater utilisation of private sector providers across Afghanistan. There is also anecdotal evidence supporting this trend. For example, WHO medical officer, Dr. Ahmed Abd El Rahman stated, *Afghanistan has made substantial progress in health care over the past few years. But the strange thing is that while the public sector is growing, the private sector is flourishing more* (Cavendish, 2010; pg. 567). However, the surveys indicate that utilisation varies regionally across the country, and no large-scale national surveys exploring utilisation have been conducted in over five years.

Therefore, although the various surveys imply there is a trend toward increasing utilisation of private sector health care providers, there is currently no conclusive broad-based data available. This is an area needing additional research. A trend toward increasing utilisation of private sector providers is not necessarily problematic for public health policy due to the complementary nature of the public and private sectors. However, it is constructive to identify what may be impacting this trend, and there is one qualitative study available that provides some possible insights.

In 2009, the MoPH mandated a Knowledge, Attitude and Practises (KAP) study to try to explain suboptimal utilisation of basic health services from public sector providers. Quotations from the KAP study are included below because they are particularly relevant (e.g. Maharam, nazrana, shura) for triangulating data collected during the current research study and are referenced in the Results section. To collect the data, the MoPH conducted a cross-sectional, qualitative study across six provinces in Afghanistan in order to represent various geographical and ethno-cultural regions and included Baghlan, Bamyan, Herat, Kabul, Laghman and Paktya provinces. Two districts were selected from each province using mixed sampling to represent the urban and rural population. The study found four major categories of barriers to utilisation including knowledge, attitude, practises and facility-based issues (Singh et al., 2012).

Knowledge barriers included health education, literacy and community participation. Public providers admit lack of awareness among the poor in communities surrounding the facility, which adversely affects utilisation. Singh et al. (2012; pg. 796) state that one respondent alleged, *Most of the elders in families have a low literacy level that causes to have their children unvaccinated... Secondly people don't rely on these vaccines and they say that the vaccines are prepared in non Muslim countries.* Further, providers mentioned the need for regular village council (shura) meetings and development of awareness programmes to improve utilisation (Singh et al., 2012).

Attitude barriers included attitude and behaviour of health providers and perception of medicine quality. Singh et al. (2012; pg. 796) cite several examples of inappropriate behaviour among public health providers towards patients. One woman complained, *My child had diarrhea, I took him to a facility, the in charge of clinic said that there is no medicine in the clinic and he quarreled with me.* Another respondent lamented the discrimination she faced and said, *They do not behave nicely with us, those who are with recommendation or are from their own tribes they are examined without any entry slip and the drug is also prescribed for them and given from the hospital.* A third respondent stated, *... a good number of people do not visit our facility because of*

unsympathetic staff. Each of the respondents was from a different province but all suggested that poor behaviour of staff discouraged community members from utilising facilities (Singh et al., 2012).

Medicine quality was another frequent criticism. The study found that many respondents across the provinces viewed medicines distributed by public providers as *loose* or inferior quality. One respondent stated, *I have a daughter, who got sick. I took her to a clinic two to three times. In my first visit doctor was not available, on second visit drug was not available, then I took her to a private clinic, which prescribed some medicine and she is alright now. The public health facility gives the same tablets to all patients for every disease* (Singh et al., 2012; pg. 797).

Practise barriers included women's autonomy, cultural practises and traditional beliefs and informal payments. The study noted that it is common practise for women to need authorisation or require a male escort to visit a health clinic. According to Singh et al. (2012; pg. 797), one man stated, *I let her (wife) to go to hospital, but with father in law, brother in law, mother in law or someone else from the family. Without Maharam (with close relatives) women cannot go to clinic*. Further, when one man was told his child's sickness could not be treated in Kabul hospitals, he opted to take his child to traditional healers. The man said, ... *Then we took him to Shrine and there also he was not cured, he is still paralyzed. We took him to a Mullah, he said to do Shishdil (slaughter the lamb, the lungs of the lamb has to be passed over the abdomen of child), we did in the same way and still my child was not cured* (Singh et al., 2012; pg. 797).

Respondents frequently reported informal payments, especially when medicines or injections were not available. The study found that it was common for there to be strong associations between public providers and private drug sellers in urban areas. Gifts, or *nazrana*, may also be demanded by staff after the successful delivery of a baby. For example, one respondent complained, ... *We are not satisfied with the delivery section of the hospital. Once I had a patient in the facility and the staff asked me money for soap, shampoo and handkerchief. In the name of sweets they took 3,000 Afs from me and we had to complain in this regard* (Singh et al., 2012; pg. 798).

Finally, facility-based barriers included physical accessibility, condition and functioning of health facilities, privacy during care and treatment and non-availability of female physicians. For respondents that live a long distance from the public facility, the cost of transportation can be a barrier. Hiring transport like a taxi or private car can cost between 200 to 500 Afghanis (\$1 US = 50 Afs). The alternative is using a donkey or donkey driven cart, which can greatly increase the amount of time it takes to reach the

facility. One respondent suggested a bridge could reduce the amount of time it takes to reach the public provider near his village. He stated, *People of my region need a bridge to be constructed, so that they can have easy access to the clinic (public health facility). Without a bridge, people have no other choice but to travel by a vehicle using long route. At present the clinic is so far that they say to reach a clinic, it is better to die at home. Last year a sick woman was drowned into river, when she was going to the facility through the river* (Singh et al., 2012; pg. 798).

Regarding condition and functioning of health facilities, Singh et al. (2012; pg. 798) cite various examples of problems with poor management, staff delinquency and inadequate facilities. One respondent explained, *I do not go the public hospital, but to the private doctor because they do faster and good diagnosis. In public hospital there is big queue from morning up to 2 o'clock and there is mis-management and no drug for poor people. Another respondent complained, The weather is cold and patients come to health facility at 7 AM from faraway places and when they arrive they are asked to receive the entry slip. After getting their entry slip patients wait for their turns, but up to 10 AM no doctor is seen (at the facility). The doctors are sitting at their homes, but the poor patients are waiting at the gate of the hospital, which sometimes causes severe damage to their health. A third respondent voiced displeasure over the quality of the physical facility, In our health facility the children and mother health care is provided but there is no heated delivery room. In hot weather we do not have problem, but in cold weather we don't have heated delivery room* (Singh et al., 2012; pg. 798).

Privacy and non-availability of female physicians were also recurring complaints among respondents. According to Singh et al. (2012; pg. 799), one respondent expressed a common complaint among villagers concerning privacy, *Our problem is that men and woman are made to wait in one hall so no one prefers to bring their bride to the health facility and take her to the delivery room crossing through waiting men patients. There should be separate waiting areas for men and women. Villagers likewise do not prefer that male doctors treat women. Thus, another frequent complaint was the lack of female doctors. For example, a separate respondent commented, In this health facility most of the deliveries are conducted but there are only midwives and no woman doctor. If here were MD doctors the quality of services would be better* (Singh et al., 2012; pg. 799).

Given the concerning results of the KAP study, more qualitative research needs to be conducted to help understand barriers to utilisation of health services in both the public and private sectors. Nation-wide quantitative surveys exploring utilisation are

also needed to provide a more up-to-date, comprehensive picture of utilisation trends in Afghanistan. As the Singh et al. (2012) qualitative study suggests, quality issues may be impacting utilisation. This is significant because Gupta (2008) indicates that higher quality health services are associated with greater utilisation such that higher quality one year leads to greater utilisation over subsequent years. Further, a study by Ameli and Newbrander (2008) found a positive correlation between client satisfaction and utilisation. Therefore, it is essential to investigate quality of care and patient satisfaction across the public and private health sectors.

2.3.4.3 Quality of Care & Patient Satisfaction

Quality of care and patient satisfaction are two central themes that are frequently cited throughout the literature concerning health sector performance in Afghanistan. Early assessment of quality of care and patient satisfaction has been almost entirely aimed at evaluation of the public health sector. However, recent assessments, while largely focused on the public sector, have also included evaluation of the private sector. The first and most widely used approach to measuring various performance metrics within the public health sector was the Afghanistan Health Sector Balanced Score Card (BSC).

The Ministry of Public Health developed the BSC to measure the performance of the delivery of the Basic Package of Health Services at both the provincial and national level. The MoPH commenced implementation of the BSC in 2004, which is considered as the baseline year of delivery. The BSC comprises six broad domains made up of 29 indicators. The domains include patients and community, staff perspectives, capacity for service provision, service provision, financial systems and overall vision. Data for the BSC are taken from the NHSPA, which was discussed in the previous section (Afghanistan Ministry of Public Health, 2004, 2008).

The first domain of the BSC, patients and community, is the most relevant domain for purposes of this comparison of public and private health sector providers in regard to quality of care and patient satisfaction. This is because the first domain contains two very important indicators – overall patient satisfaction and patient perception of quality index. In particular, patient perception of quality index includes nine separate items such as convenience of travel to health facility, courtesy and respect of staff and explanation of illness and treatment that collectively encompass the overall indicator. Scores for overall patient satisfaction and patient perception of quality index are based on statements read to patients during exit interviews. During the interview,

each respondent is asked to rate his or her level of agreement with various statements relating to a four-point Likert-type scale. Each point on the scale is represented by Afghan bread called naan (Afghanistan Ministry of Public Health, 2004; Hansen et al., 2008c).

In the survey, one naan equals strongly disagree, two naan disagree, three naan agree and four naan strongly agree. Patients simply point to a photograph with the number of naan that best represents their level of agreement with each particular statement. The naan scale was developed through formative research and field-testing, and participants in this context were able to understand the scale fairly easily. The approach is not without precedence. Similar methods to measuring perceptions of health services have been attempted in previous studies such as using varying denominations of money, or as with the NHSPA, different numbers of pieces of locally made bread. The indicators are subsequently calculated as percentages on the BSC (Hansen et al., 2008c; Rao et al., 2006; Willis, 2006).

In 2004, the national median score for overall patient satisfaction was approximately 83%. Although the national median score was relatively high, the ratings for individual provinces fluctuated widely between 62% and 98%. The national median score increased slightly during 2005 and 2006, but dropped back to 81% in 2008. Again in 2008, provincial ratings varied widely between 60% and 96%. The national median score for patient perception of quality index in 2004 was 76%. It increased to as much as 80.3% in 2006 before falling back to 77.5% in 2008. Although the national median score increased slightly between 2004 and 2008, the provincial ratings also varied widely. The provincial ratings fluctuated from approximately 54% to 87% in 2004 and from roughly 67% to 97% in 2008. The overall national median scores for both indicators remained quite high between 2004 and 2008. However, the variations among the provinces suggest that each province is providing different levels of service and may have diverse areas of concern. In fact, one of the most significant findings of the BSC is that wide variations in performance across provinces existed in every domain (Afghanistan Ministry of Public Health, 2008; Peters et al., 2007).

Further, Hansen (2008) studied measures of quality of care as well as client perceptions of service quality in Afghanistan using data from the 2004 NHSPA. In one published study, Hansen et al. (2008a) identified four dimensions of quality of care including patient histories, physical examinations, communication and time spent with patients. The various dimensions were based on indicators from the BSC. In this study, Hansen et al. (2008a) found that the strongest association with quality involved patient

and provider gender. When both the patient and provider were female, service quality was much higher. The research also revealed that the level of quality was higher when a doctor was the provider. Provider care and gender were also found to be associated with quality of care in another study on the trends on the quality of health care of children under the age of five in Afghanistan (Edward et al., 2009). In addition, the Hansen et al. (2008a) study found that a higher frequency of supervision visits was associated with higher quality. On the other hand, remoteness, facility type, provision of timely salary payments and in-service training were found not to be associated with quality.

In a separate published study, Hansen et al. (2008c) tested several independent variables for their association with client perception of quality. The study found the two variables with the strongest correlation with perceived quality were patient history and physical examination and patient counseling. Therefore, the greatest determinant of customer perception of quality was found to be health worker thoroughness in taking patient histories and conducting physical exams and communicating with patients. In fact, the study found that the majority of the variation in client perception of quality related to the patient's interaction with the health worker and not to other characteristics such as physical condition of the facility, maternal and child health service capacity, functional equipment availability and functional drug availability. Consequently, it is essential to include patient history and physical examination and patient counseling in assessing and comparing quality of care and patient satisfaction in the public and private health sectors in Afghanistan.

The indicators from the BSC that correspond to the quality of care characteristics cited by Hansen et al. (2008a, 2008c) fall under the third domain of the BSC, service provision, and include patient history and physical exam index, patient counseling index and time spent with patient (Afghanistan Ministry of Public Health, 2008). The first two indicators include a total of 15 sub-items pertaining to the health worker's interaction with the patient or caretaker. First, the patient history and physical exam index is comprised of six items that assess whether the health worker asked the patient's age, greeted the patient, inquired about the complaint, asked about the duration of the complaint, sought information about previous treatments, examined the patient and ensured the patient's privacy. In 2004, health workers completed almost 71% of the steps involved in conducting patient histories and physical exams. This number has improved steadily every year, and in 2008, the patient history and physical exam index was nearly 84% (Afghanistan Ministry of Public Health, 2008).

Second, the patient counseling index is comprised of nine steps for providing basic information and counseling to patients or caretakers which includes describing the name of the ailment, explaining necessary precautions, providing the name of the medicine, instructing how to handle adverse reactions, scheduling a return visit or making a referral and asking whether there are any questions. The patient counseling index is not nearly as positive as the patient history and physical exam index. In 2004, the patient counseling index was a mere 29.6%, which means that health workers completed less than one-third of the steps involved in providing basic information and counseling to patients. The index increased to 48% by 2008, but the absolute score remained low, which is a concern regarding quality of care in the public health sector in Afghanistan (Afghanistan Ministry of Public Health, 2008).

The third indicator, time spent with patient, assesses the average time the health worker spends with the patient, and the score reveals the percentage of health workers that observed a minimum of nine minutes with the patient. Only 18% of health workers spent at least nine minutes with patients in 2004. The percentage plummeted to 6.2% and 7% in 2005 and 2006, respectively. The score rebounded back to almost 20% in 2008, but it was barely above the 2004 level. Time spent with patient received the lowest absolute scores of all indicators relating to quality of care and patient satisfaction. Thus, the large declines in 2005 and 2006 along with the overall low absolute level of time spent with patient is cause for concern regarding the level of quality of care provided by health workers in the public sector (Afghanistan Ministry of Public Health, 2008; Hansen et al., 2008b).

Finally, one additional BSC domain contains an indicator that may indirectly impact quality of care and patient satisfaction. The health worker satisfaction index is included in the second domain, staff perspectives, and is comprised of 19 separate items. Items include those such as salary, relationship with local leadership, availability to provide high quality care and ability to meet needs in the community. The national median score for health worker satisfaction index increased from almost 64% in 2004 to approximately 69% in 2008. The score increased slightly between 2004 and 2008, but health worker satisfaction is still much lower than overall patient satisfaction. Health worker satisfaction is important because it impacts employee motivation and retention, which can influence management of implementing agencies. This may have a residual effect on quality of care and patient satisfaction (Afghanistan Ministry of Public Health, 2008; Edward et al., 2011).

Given the history of health care in Afghanistan, results from BSC indicators regarding quality of care and patient satisfaction from 2004 to 2008 provide a moderately encouraging outlook overall for public health care provision in Afghanistan. In addition, patients in remote areas appear to be receiving quality of care that is comparable to those in non-remote areas (Johns et al., 2013). However, there are limitations regarding BSC results. One major limitation is that satisfaction ratings of customers in facility-based surveys tend to be biased as a result of courtesy bias. This type of bias occurs where patients, particularly in exit interviews, provide favourable but misleading responses. Courtesy bias can be even higher regarding subjective perceptions of facility personnel such as physician behaviour or staff attitudes. Moreover, while the BSC provides a wide range of indicators that provide a basis for measuring performance, it contains relatively little data health outcomes in Afghanistan (Edward et al., 2011; Glick, 2009; Peters et al., 2007; Trani et al., 2010).

One final limitation that emerges when making health-related assessments based on quality of care and patient satisfaction is that patients may lack the ability to properly judge between what they want and what is actually good for their health. For example, it is known that Afghans particularly like being prescribed medications whether in the form of a pill or injection. Patients may be satisfied because they were prescribed what they wanted, but that does not prove the prescription was warranted. On the other hand, patients may be dissatisfied if they are not prescribed medications even if the treatment is unnecessary. Therefore, the results of health assessments regarding this type of qualitative judgement may be open to the interpretation of the respondent (Maury, 2005).

In particular, courtesy bias is one limitation of the BSC that could be accounted for by including a household survey as part of the annual NHSPA. Household-based surveys typically portray a less-biased account of actual quality of care and patient satisfaction regarding health providers. The only national household survey regarding public health sector performance was conducted as part of the baseline NHSPA in 2004. Therefore, the MoPH could reduce courtesy bias by including household surveys again as part of the annual NHSPA in addition to the facility-based interviews. Furthermore, it is important to consider other available household surveys regarding public and private health sector performance in Afghanistan. Unfortunately, no national household surveys have been administered that either assess private health sector performance or compare performance between the public and private sectors. However, two studies regarding quality of care and patient satisfaction are available that provide limited assessment of

private health sector performance and some comparison of performance between the public and private sectors.

Both studies addressing quality of care and satisfaction were included in the previous section regarding utilisation. The first, Afghanistan Private Sector Health Survey, assessed how households viewed the quality of health services as well as perceived outcomes of visits. When asked to rate the quality of health services a household member had received, approximately 70% of respondents visiting public providers rated services adequate versus roughly 68% for those visiting private providers. Only about 18% of respondents visiting public providers rated the services very good/but could be better compared to almost 21% of respondents visiting private providers. A mere 2.9% of respondents visiting public providers rated services excellent/couldn't be better versus 4.3% of those visiting private providers. Nearly 7% of respondents rated services of public providers not very good while only about 2% rated services terrible. For private providers, the ratings were similar. Roughly 5% of respondents rated services not very good while about 2% rated services terrible (Alsi et al., 2009).

When asked to rate the outcome of their visit to health care providers, nearly 53% of respondents visiting public providers said services probably helped, improvement noticed while only about 44% of respondents visiting private clinics provided the same response. However, about 24% of respondents visiting public providers said services definitely, helped a lot versus 31.5% of respondents visiting private clinics. Only 4.7% of respondents visiting public providers said the visit was maybe worth the cost/effort, but not much good resulted and 5% stated maybe, can't see much difference. Of respondents visiting private clinics, 7% said the visit was maybe worth the cost/effort, but not much good resulted and 6.1% stated maybe, can't see much difference. A mere 0.6% of respondents visiting public providers said the visit was definitely not worth cost/effort; no good resulted/maybe some bad compared to 1.5% of respondents visiting private clinics (Alsi et al., 2009).

Private sector providers were rated somewhat more positively (very good/but could be better or excellent/couldn't be better) than public sector providers regarding quality of service – 25% versus 21.1%, respectively. Public sector providers were rated slightly more negatively (not very good or terrible) than private sector providers – 8.6% versus 7%, respectively. Conversely, public sector providers were rated slightly more positively (probably helped, improvement noticed or definitely, helped a lot) than private sector providers regarding perceived outcomes of visits – 77.1% versus 75.6%,

respectively. Private sector providers were rated somewhat more negatively (maybe worth the cost/effort, but not much good resulted, maybe, can't see much difference or definitely not worth cost/effort; no good resulted/maybe some bad) than public sector providers – 14.6% versus 10.3%, respectively. Therefore, the APSHS found that satisfaction was positive overall concerning service quality for both public and private sector providers, and health services were generally considered to be of equivalent quality between the two sectors. In regard to perceived outcome of patient visits to health care providers, the APSHS found households were again quite positive about the outcomes of their visits and there were no significant differences in ratings of public and private sector providers (Alsi et al., 2009).

The second study, conducted by Cockcroft et al. (2011), included health service ratings in three areas – reception from the health worker, quality of care compared with expectations and overall satisfaction with the services. As mentioned earlier, this study included a survey that was administered in two districts in Kabul comparing government operated health facilities, operated primarily through the Strengthening Mechanism, against NGO contracted health facilities. The study also compared overall public sector (including SM and NGO) providers against private sector providers in each district. Private providers were generally rated higher than public providers in most categories. For example, private providers received the highest ratings regarding reception from the health worker in both provinces. Patients of private providers in the SM and NGO districts rated reception from the health worker good or very good approximately 96% and 93% of the time, respectively. Patients of public providers in the SM and NGO districts rated reception from the health worker good or very good only about 80% and 76% of the time, respectively.

Patients of public providers were less likely to report that care was better than expected, and they were less likely to be satisfied with overall care. In the SM district, approximately 37% of patients using public providers said quality was better than expected and almost 67% were satisfied with overall care. In the NGO district, roughly 48% of patients using public providers said quality was better than expected and about 67% were satisfied with overall care. Conversely, more than 68% of patients of private providers said quality was better than expected and nearly 84% were satisfied with overall care in the SM district. However, in the NGO district, only 36% of patients of private providers said quality was better than expected and roughly 46% were satisfied with overall care. Although ratings were lower for private providers in the NGO district,

there were a much smaller number of patients using private providers in that district (Cockcroft et al., 2011).

In summary, the BSC provides comprehensive assessment of public health sector performance regarding quality of care and patient satisfaction whereas data on private sector performance is very limited. Additional research is needed concerning both public and private health sector performance because NHSPA data used for the BSC is gathered from facility-based surveys, and generalisable data from national household surveys is lacking from both sectors. However, the available data reveals that patients in both sectors generally rate quality of care and patient satisfaction positively. Moreover, quality of care and patient satisfaction appear to be relatively comparable between public and private providers.

2.3.4.4 Cost

Cost, principally in the form of user fees, is one final important point of comparison between the public and private sector because cost has been found to impact both utilisation and quality of care. For example, some studies have found that user fees cause utilisation to decrease while other studies have found just the opposite. Therefore, evidence on the impact of user fees upon utilisation is mixed (Jacobs and Price, 2004; Palmer et al., 2004; Peters et al., 2008; Rao and Peters, 2007). Several studies have shown that user fees are associated with improved quality of care and that increases in quality outweigh the negative impacts on utilisation (Audibert and Mathonnat, 2000; Chawla and Ellis, 2000; Rao and Peters, 2007).

Ridde et al. (2012) suggest exempting patients from user fees may result in various dysfunctions in the health system such as decline in health worker morale, unavailability of drugs and insufficient funding. Charging user fees may also be effective in contexts where corruption is commonplace by replacing and formalising informal payments (James et al., 2006). However, despite concern regarding the quality of available evidence on the subject of charging for health services in low-income countries (Lagarde and Palmer, 2008; Ridde et al., 2012), there is a growing opinion among global health actors that user fees should be abolished (Robert and Ridde, 2013; Yates, 2009).

In Afghanistan, most public health sector providers were charging user fees as the MoPH expanded the BPHS. In 2004, 70.4% of public providers were charging user fees, and number increased to 84.3% by 2007. User fees charged by public providers were not standardised. In addition, some providers charged for pharmaceuticals while

others provided them free of charge. Sparse data is available concerning the extent to which fees cover expenses, and there is little empirical evidence concerning the impact of user fees upon utilisation and quality of care in Afghanistan (Islamic Republic of Afghanistan, 2008a).

However, one limited study concerning public sector user fees in Afghanistan is available. Steinhardt (2010) assessed a health financing pilot implemented by the MoPH in order to determine the effects of user fees on utilisation and the quality of care of primary care in Afghanistan. The pilot was conducted during 2004-2005 in 10 out of the 34 provinces, and final data collection took place in 2007. Data sources included health management information system (HMIS) data, NHSPA data and qualitative interviews with facility staff and community leaders.

Three types of interventions were piloted – a user fee arm, a community health fund arm and a free services arm. In each participating province, the MoPH or NGO service provider chose five pilot facilities based on their readiness to implement the pilot. Two of the three interventions were piloted in each province. Of the five facilities in each province, two were randomised to one intervention such as user fees and two were randomised to the second such as free services. The fifth facility in each province functioned as a control by continuing whatever user fee related structure was currently in place (Islamic Republic of Afghanistan, 2008a; Steinhardt, 2010).

Steinhardt (2010) found that outpatient visits increased 32% overall from the one-year period before the pilot to one year after implementation. However, the increase was much higher among facilities providing free services (102%) compared to facilities charging user fees (22%). Qualitative interviews at one facility revealed that although utilisation improved as a result of free services, the increase in patients had a negative effect on the clinic. The clinic struggled to effectively manage the influx of new patients. Facility staff and community leaders complained free services had caused clinics to become overcrowded with patients making it difficult for providers to deliver high quality care. However, despite complaints by staff and community leaders in qualitative interviews, Steinhardt's (2010) results demonstrated that user fees had little effect on observed or perceived quality. In fact, facilities providing free services exhibited slightly larger improvements in observed quality than facilities charging user fees.

Thus, evidence from the health financing pilot in Afghanistan indicated that utilisation of curative care increased when public facilities provided free health services and that the removal of user fees did not negatively impact quality of care. The pilot

study did, however, face substantial limitations such as lack of generalisation due to the small number of health facilities involved, incomplete HMIS data and courtesy bias from facility-based surveys. Regardless of the limitations, the pilot study had significant implications for public health care policy in Afghanistan. The MoPH decided to ban user fees at public health care facilities soon after presentation of the pilot study results, and the ban was officially implemented in April of 2008 (Steinhardt et al., 2011).

Although the MoPH has officially banned public health care providers from charging user fees, this does not mean that public health care is free. The Cockcroft et al. (2011) study found that one out of seven patients surveyed paid for care received by public providers, and 75% of patients surveyed paid for medicine outside of the clinics. Similarly, the Singh et al. (2012) study found an association between doctors at public health providers and private drug sellers. Doctors often informed patients of poor quality drugs or shortages of medicines and advised them to purchase from private drug stores near the public health facility. In fact, the study indicated that a majority of patients reported considerable expenditure from free public health providers, especially in the case of where medicines and injections were not available. Singh et al. (2012) also explain that there is a common practise of medical staff demanding a gift, or nazrana, after the successful delivery of a baby.

WHO medical officer, Dr Ahmed Abd El Rahman, suggests why informal payments may be common in the public health sector in Afghanistan, *If you have a low budget for health care and patients come, what do you do? You tell them they have to buy their medicines. So, although health care is declared to be free, in fact it is not. It pushes people to the private sector because they think they will receive better service. Patients perceive 'this clinic has a bad director, they don't have medicines. If I go to the private sector I will get a good doctor and there will be medicines'* (Cavendish, 2010; pg. 567). Therefore, there is some limited evidence that informal payments to public sector providers may be common even though user fees have been banned. However, apart from the limited evidence, there is no generalisable, nation-wide data available.

In contrast to the public health sector, private sector providers do not face the same regulatory scrutiny regarding user fees. The private sector is poorly regulated overall, and very little data is available regarding cost of care. The 2006 AHS and the 2008 APSHS do, however, provide some limited comparative data between public and private sector providers regarding cost of care. The 2006 AHS was conducted before the abolition of user fees, and it provided household data on out-of-pocket expenditures by health provider type. The survey found that the total median amount charged by public

health providers was 150 Afghans compared to 600 Afghans at private health providers (Afghanistan Ministry of Public Health, 2006).

The 2008 APSHS was administered just months after the MoPH officially banned user fees, and like the AHS, it also included household data on cost of health visit by provider type. The APSHS measured the proportion of public and private sector providers' health services that were rated by households as free or cheap (0-50 Afs), moderately priced (51-100 Afs) or expensive (>100 Afs). Almost 73% of visits to public providers were free or cheap compared to only about 10% of visits to private providers. More than 48% of visits to private providers were moderately priced versus 10.5% of visits to public providers. Only about 17% of visits to public providers were expensive compared to 42% of visits to private providers (Alsi et al., 2009).

Therefore, the vast majority of visits to private providers (90%) were moderately priced or expensive in contrast to only a minority of visits to public providers (27%). It is important to note that almost two-thirds of visits to private providers paid less than 250 Afs, and only about 12% of visits to private providers cost more than 500 Afs. Although the survey found that the average cost of a visit to a private provider (348 Afs) was almost two and a half times as much as a visit to a public provider (144 Afs), their charges were still mostly rated as moderately priced (Alsi et al., 2009).

As a result, the surveys reveal that although private providers are more expensive than public providers, most private providers charge reasonable prices. However, it is likely that the cost differential between public and private providers has increased because the user fee ban was implemented only months prior to the APSHS. Therefore, additional research needs to be conducted assessing the cost of care associated with visiting public and private providers. Cost comparisons between public and private sector providers should be evaluated, and informal payments made to public providers should be taken into consideration.

2.3.5 Summary of Health Care in Afghanistan

The health care sector in Afghanistan has come a long way since 2001 when provision of health care was virtually nonexistent across the country and health indices were among the worst in the world. However, when the public health care sector was established, the MoPH was able to quickly scale health care service across Afghanistan through contracting with NGOs. At the same time, a burgeoning private sector has developed alongside the public health sector. The public and private health care sectors have grown significantly in the last decade, and as some authors suggest, the two sectors

are reasonably complementary (Alsi et al., 2009; Bartlett et al., 2005; Loevinsohn and Sayed, 2008; Newbrander et al., 2011; Strong et al., 2005).

Further, utilisation, quality of care, patient satisfaction and cost of care are important areas of comparison necessary for understanding the similarities and differences between the public and private health sectors. For example, although the public and private health sectors are somewhat complementary, there appears to be a growing trend towards utilisation of private sector providers overall. However, surveys indicate that utilisation varies regionally across the country, and no large-scale national surveys exploring utilisation have been conducted in over five years (Afghanistan Ministry of Public Health, 2004, 2006; Alsi et al., 2009; Trani et al., 2010). Quality of care and patient satisfaction are two central themes frequently cited throughout the literature concerning health sector performance in Afghanistan, and studies reveal that quality of care and patient satisfaction impact utilisation (Ameli and Newbrander, 2008; Gupta, 2008; Singh et al., 2012). In addition, cost of care is a critical consideration because cost has been linked to utilisation, quality of care and patient satisfaction (Chawla and Ellis, 2000; Peters et al., 2008; Rao and Peters, 2007).

In conclusion, the literature concerning the health care sector in Afghanistan establishes an important backdrop, or context, for the research because the organisation involved in the study, Morning Star Development (MSDEV), is a private provider of health care services in Afghanistan. The organisation has been providing health services since 2003, so it has been active during the development of the health care sector. Thus, the various topics discussed above including organisation, operation and funding of the public health care sector, overview of the private health care sector, the public-private overlap, utilisation, quality of care, patient satisfaction and cost are essential for assessment of MSDEV's impact on the communities it serves.

2.4 SYNTHESIS AND LITERATURE GAP

The BoP field is still relatively new (only about a decade old), but there have been significant advancements throughout the literature. Various authors have added to the BoP literature in each of the four areas outlined earlier – BoP demographic, BoP market, BoP approach and BoP perspective. While the BoP demographic and BoP market are interrelated, the BoP approach and BoP perspective are distinct and individually compared to the transnational approach to global strategy and traditional approaches to poverty alleviation, respectively. Additionally, the BoP approach and BoP perspective build upon the concepts of the BoP demographic and BoP market.

For instance, the BoP demographic has been described primarily by income such that approximately four billion people earn less than \$3,000 (in 2002 PPP) per capita (Hammond et al., 2007; London and Hart, 2011). However, the BoP demographic is also characterised by diverse characteristics such as significant unmet needs, existence in the informal or extralegal economy and subjectivity to the poverty penalty (De Soto, 2000; Hammond et al., 2007; London and Hart, 2011; Prahalad, 2010).

Understanding these social and legal characteristics is critical when targeting diverse BoP markets, which have a global aggregate market potential of five trillion dollars (Hammond et al., 2007; London and Hart, 2011; Prahalad, 2010). The BoP market is attractive in part because it is a latent market that represents a significant untapped business opportunity (Prahalad, 2010). To understand the BoP market, it is necessary for organisations to become socially embedded in the local community, develop partnerships and co-create solutions (Brugmann and Prahalad, 2007; Hart and London, 2005; London and Hart, 2004; London and Rondinelli, 2003; Prahalad and Ramaswamy, 2002).

Concerning the BoP approach to global strategy, London and Hart (2004) demonstrate that it goes beyond the widely accepted transnational model, or approach. The transnational approach is based upon organisational capabilities such as worldwide learning, national responsiveness and global efficiency (Bartlett and Ghoshal, 1989). The BoP approach, on the other hand, requires native capability and innovative strategies such as collaborating with non-traditional partners, co-inventing custom solutions, building local capacity, avoiding dependence upon central institutions and creating social, not legal, contracts. Because the BoP approach requires a market entry strategy beyond importing and adapting business models through worldwide learning and sharing knowledge within company borders, firms must engage in business model development (Hart and London, 2005; London, 2010; London and Hart, 2004). Further,

to successfully serve BoP markets, firms should leverage marketing insights such as marketplace research, identifying critical needs, establishing partnerships to co-create value, designing value propositions based on affordability and tradeoffs, communicating to consumers, providing access to products and managing the adoption process (Sridharan and Viswanathan, 2008; Weidner et al., 2010).

The BoP perspective is identified in the literature as an alternative, market-oriented approach to poverty alleviation. Traditional approaches to poverty alleviation can include Western development aid and philanthropic charity as well as social enterprise or microfinance (Chambers, 1997; Dart, 2004; Kandachar and Halme, 2008; Yunus and Weber, 2010). The BoP perspective is different from traditional approaches because it views the poor living in the BoP demographic as value conscious consumers and holds that meeting their unmet needs is a market opportunity that can be served by private enterprise (Prahalad, 2010). Further, there are six principles that, when combined, distinguish the BoP perspective from traditional approaches to poverty alleviation. The principles include external market participation, co-creation, connecting the local with the non-local, patient innovation, self-financed growth and focusing on what is right at the BoP (London, 2007 (July)).

Much of the literature concerning the BoP perspective is based upon numerous ventures that have been launched during the last decade. Cases that analyse these BoP ventures and highlight successes and failures have been important for development of the BoP perspective. However, there is reason to accept the results with caution. Keeping in mind that the central premise of a BoP venture is mutual value creation, comprehensive evidence concerning positive poverty alleviation outcomes are lacking. Additionally, the BoP venture successes that are illustrated throughout the literature typically use anecdotes to describe positive impact upon poverty alleviation. In other words, this means that the central premise of the BoP concept is not well supported in the literature. Thus, research regarding impact assessment, or how BoP ventures are helping the poor, is a critical area in the literature requiring empirical research (London, 2007 (July), 2009b).

Further, whether organisations engaging the BoP market lack proper systems or merely identify the wrong measures, comprehensive, empirical assessment of BoP venture impact upon poverty alleviation in the literature is virtually non-existent. Therefore, it has been very difficult to gauge the efficacy of BoP ventures. For example, London (2009b; pg. 107) states, *...organisations that deliver products to and purchase goods from the base of the pyramid usually don't have robust-enough systems to*

accurately assess how well they're reaching the people they set out to serve – or they simply look at the wrong measures. They judge their success at alleviating poverty on the basis of tasks completed and milestones achieved – amount of money invested, quantity of products distributed, number of interventions initiated, and so on – rather than on how well their activities translate into changes on the ground.

Thus, while many organisations are launching BoP ventures, there is little empirical evidence in the literature that actually substantiates impact upon poverty alleviation. As London (2007 (July); pg. 31) suggests, mutual value creation is *...an exciting hypothesis, but at this stage, it remains that – a hypothesis that requires more comprehensive testing to better understand the interactions and boundary conditions in the relationship between profits and poverty alleviation.* Assessment is therefore a crucial gap within the BoP literature that needs further development. Addressing this gap in the BoP literature is critical because the central premise of a BoP venture (e.g. mutual value creation) cannot be proven without comprehensive assessment of BoP venture impact upon poverty alleviation. Consequently, the BoP concept cannot be substantiated without empirically demonstrating that the BoP venture has actually helped the poor.

There is one framework available that provides a holistic approach to measure comprehensive impact of a BoP venture upon poverty-alleviation outcomes – the BoP Impact Assessment Framework (London, 2009b; London and Anupindi, 2010). Therefore, using this framework, the gap in assessment is addressed through an empirical research study of a health care venture targeted at the BoP market in Afghanistan. Further, testing the BoP Impact Assessment Framework is valuable because the framework has only been applied in few contexts. Therefore, the research aims to address the literature gap and generate insights regarding impact of BoP ventures upon poverty alleviation by testing the existing framework in a new context. Ultimately, the intended result is to test the framework and provide empirical evidence regarding whether, or how, a BoP venture is helping the poor.

To test the existing framework, it is important to establish background for the research study. This is required because the study takes place in a very unique context – the BoP health sector in Afghanistan. Therefore, using income as the focal point, BoP market segmentation by region, country and sector is provided to establish context for the research study. The Next 4 Billion report is the standard for understanding global BoP market segmentation. However, there is no data available for Afghanistan because household surveys for the country are not available. As a result, the report does not

include Afghanistan as one of the countries involved in its analysis of the global BoP market (Hammond et al., 2007). Thus, the current research study estimates the size and structure of the Afghanistan BoP market and BoP health sector using averages from similar surrounding countries included in The Next 4 Billion report as well as from additional external data. For example, it is likely that the Afghanistan BoP market is bottom heavy and rural and that spending in the BoP health sector is concentrated in the bottom three segments – BOP1500, BOP1000 and BOP500.

Although estimating segmentation of the BoP market in Afghanistan is important for establishing context for the research study, the BoP literature provides no information concerning health care in Afghanistan. As a result, more detailed knowledge concerning the Afghanistan health care literature is required to effectively address the gap in the BoP literature. For example, health care in Afghanistan is primarily provided through the public sector (Transitional Islamic Government of Afghanistan, 2003), but the focus of the research study is a private health care provider. In addition, there is some overlap between the public and private sector (Alsi et al., 2009). Therefore, exploring literature on both sectors in Afghanistan is important to understand how impact might be measured.

Furthermore, utilisation, quality of care, patient satisfaction and cost are central themes within the Afghanistan health care literature that impact how assessment might be measured. For example, although the public and private health sectors are somewhat complementary, there appears to be a growing trend towards utilisation of private sector providers overall (Afghanistan Ministry of Public Health, 2004, 2006; Alsi et al., 2009; Trani et al., 2010). Singh et al. (2012) explain that various barriers may be impacting utilisation of health services in Afghanistan. Barriers include knowledge, attitude, practises and facility-based issues, which may be negatively impacting quality and patient satisfaction.

Quality of care and patient satisfaction are significant because studies reveal they impact utilisation (Ameli and Newbrander, 2008; Gupta, 2008; Singh et al., 2012). Cost of care is a critical consideration because cost has been linked to utilisation, quality of care and patient satisfaction (Chawla and Ellis, 2000; Peters et al., 2008; Rao and Peters, 2007). Therefore, since Morning Star Development is a private provider of health care services in Afghanistan, understanding the relationship between the public and private health sectors, utilisation, quality of care, patient satisfaction and cost are essential for comprehensive assessment of the organisation's impact on the communities it serves.

In summary, defining, exploring and integrating the BoP literature and the Afghanistan health care literature is important for identifying and addressing the gap in the BoP literature regarding assessment and establishing context for the research study. Moreover, the BoP Impact Assessment Framework provides a general theoretical framework for designing the study, which is required to address the literature gap. The framework contains three main categories – “potential changes in economics”, “potential changes in capabilities” and “potential changes in relationships”. The categories intersect with three main stakeholders – buyers, sellers and the community. A blank sample of the BoP Impact Assessment Framework is provided below.

Sellers	Buyers	Community
POTENTIAL CHANGES IN ECONOMICS		
POTENTIAL CHANGES IN CAPABILITIES		
POTENTIAL CHANGES IN RELATIONSHIPS		

Figure 2.32: BoP Impact Assessment Framework (SOURCE: London, 2009b)

It is important to explain the categories of the BoP Impact Assessment Framework in order to understand how the current research study is designed to test the framework, which is discussed further in the following chapter. For example, the first category of the BoP Impact Assessment Framework, “potential changes in economics”, contains a variety of potential economic impacts such as income or revenue, income stability and savings. Other impacts may include changes to assets, debt or even productivity. In addition, there may be a combination of several different impacts that are positive or negative such as increased income and savings but decreased income stability (Esper et al., 2014).

The second category on the BoP Impact Assessment Framework is “potential changes in capabilities”. The category is much broader and relatively more abstract compared to the first category. Further, the second category pertains to social impact of a BoP venture whereas the first category clearly relates to economic impact. For instance, social impacts relating to capabilities include knowledge, skills and self-confidence. However, in addition to direct effects from increased knowledge and skills, social impacts relating to capabilities may broadly range from changes in physical and psychological health to personal dignity and individual or collective aspirations. Similar to the first category, impacts may be both positive and negative (Esper et al., 2014).

The third category on the BoP Impact Assessment Framework is “potential changes in relationships”. Like the second category, this last category pertains to social impact of a BoP venture. Thus, two of the three categories are derived from social impact while only a single category represents economic impact. The third category is also a very wide-ranging category (like the second category). For instance, “potential changes in relationships” can include direct impacts to social support, social networks and relationships with spouses and other family members. However, it can further include more subtle impacts such as roles or status within the family and society as well as values and beliefs about society. Changes in relationships may include positive or negative impacts, which is similar to the other categories (Esper et al., 2014).

The following table summarises all potential changes within each category (e.g. economics, capabilities and relationships) of the BoP Impact Assessment Framework. This table illustrates a comprehensive list of potential impacts regarding the BoP Impact Assessment Framework, and the list is essential for understanding how impact is comprehensively defined within the framework. As mentioned earlier, expounding the categories of the BoP Impact Assessment Framework is necessary to understand how the research study is designed to test the framework, which addresses the gap in the BoP literature.

BoP Impact Assessment Framework Category Composition

Potential Changes in Economics	Potential Changes in Capabilities	Potential Changes in Relationships
+/- Income/Revenue	+/- Physical health	+/- Social support
+/- Income stability	+/- Psychological health	+/- Social networks
+/- Savings/Assets	+/- Knowledge	+/- Relationship with spouse
+/- Debt	+/- Skills	+/- Relationship with family members
+/- Economic risk	+/- Self-confidence	+/- Support to family members
+/- Cost to engage venture	+/- Self-efficacy	+/- Interactions with family members
+/- Productivity	+/- Self-worth	+/- Roles/status
+/- Expenditure	+/- Empowerment	+/- Access to formal institutions
	+/- Contentment	+/- Values and beliefs about society
	+/- Dignity	+/- Local environment
	+/- Aspirations	+/- Ecosystem outcomes
		+/- Home environment

Table 2.5: BoP Impact Assessment Framework Category Composition (SOURCE: Esper et al., 2014)

For instance, Yin (2009) advocates that existing frameworks can provide a rich background or general blueprint for designing case studies (method used in the research study) and testing existing theories. Miles (1979) suggests that researchers who develop grounded theory (data analysis approach used in the research study) often encounter many challenges if a rough framework is not in place. In grounded theory, general categories (from an existing framework) may inform initial data collection, but data is collected inductively and final categories emerge from the raw data (Strauss and Corbin, 1998).

Therefore, the BoP Impact Assessment Framework provides preliminary categories that influence initial study design, and the research question, aim and objectives are designed to test the framework (existing theory). Testing the theory essentially results in revealing whether or not the categories are relevant or apply within a unique context – BoP health sector in Afghanistan. Thus, the existing framework not only influences the initial approach to data collection and theory development, but it also acts as a theoretical template with which to generalise empirical results (theory) of the research study. The ultimate aim of the research study is to test, elaborate and extend that theory in order to address the gap in the BoP literature.

CHAPTER: 3 STUDY DESIGN

3.1 RESEARCH QUESTION, AIM AND OBJECTIVES

As previously mentioned, there is a gap in the BoP literature in regard to assessment. Many case studies on BoP ventures have been written and analysed but holistic assessment is lacking (London, 2007 (July), 2009b). There is one author in particular, Ted London, who emphasises this serious need for comprehensive assessment. Although London (2009b) has developed a holistic assessment tool, external parties should test its validity in various national and cultural contexts as discussed in the previous chapter. Therefore, evaluation of the BoP Impact Assessment Framework represents an important contribution toward addressing the gap in assessment in the BoP literature.

The Base of the Pyramid Impact Assessment Framework contains two elements – the Strategic Analysis and the Performance Analysis. The Strategic Analysis requires qualitative research and involves saturating the categories of the framework, which were expounded on in the previous chapter. Thus, the Strategic Analysis relates to understanding and improving impact and is completed prior to initiating the Performance Analysis. The Performance Analysis, on the other hand, is a separate process and involves developing a set of indicators identified from the Strategic Analysis to track impact over time. Therefore, the research question, aim and objectives are designed to test (e.g. externally assess or validate quality, performance or reliability using a set of procedures) the Strategic Analysis element of the framework.

In order to test the framework (existing theory), the research question, aim and objectives address two main areas. First, the framework is tested in regard to its effectiveness for organisations to understand impact of their BoP ventures. In order to comprehensively understand impact, the research must ascertain what impact has actually been realised. However, it is imperative that the research goes beyond simply addressing the what question. Therefore, it is essential that the research describe how impact has been achieved and why impact has occurred. More is discussed concerning questions of what, how and why in the following sections below.

The research study develops holistic understanding through measuring both economic impact and social impact upon the communities in which an organisation serves. The terms economic and social are the general themes covered by the framework, so they were accordingly framed in the research question, aim and objectives. Further, holistic understanding requires evaluation of positive and negative

impacts. Therefore, achieving understanding involves developing a holistic knowledge of all positive and negative economic and social impacts of a BoP venture on areas such as income, economic opportunities, skills gained through training, self-confidence, health and morbidity, gender equality and community roles and relationships (London, 2009b).

Second, the framework is tested in regard to its effectiveness for organisations to improve impact of their BoP ventures. Once economic and social impacts are understood, the organisation is in a position to determine how to improve impact. Improving impact may include enhancing positive impacts and mitigating or eliminating negative ones. Therefore, the following research question, aim and objectives have been developed to address understanding and improving both economic and social impact.

The research question is:

- Is the BoP Impact Assessment Framework an effective assessment tool for organisations to understand and improve their economic and social impact in the communities they serve?

The aim of the research is:

- To test whether the BoP Impact Assessment Framework is an effective assessment tool for organisations to understand and improve their economic and social impact in the communities they serve.

The objectives of the research are:

- To test whether the BoP Impact Assessment Framework is an effective assessment tool for organisations to understand their economic impact in the communities they serve.
- To test whether the BoP Impact Assessment Framework is an effective assessment tool for organisations to understand their social impact in the communities they serve.
- To test whether the BoP Impact Assessment Framework is an effective assessment tool for organisations to improve their economic impact in the communities they serve.
- To test whether the BoP Impact Assessment Framework is an effective assessment tool for organisations to improve their social impact in the communities they serve.

3.2 RESEARCH PARADIGM AND THEORETICAL FRAMEWORK

In designing the research paradigm and theoretical framework, four levels are addressed including the philosophical level, the analysis level, the operational level and the candidate level. First, at the philosophical level, the chosen research paradigm is phenomenological. Phenomenology is a philosophy that is concerned with how individuals make sense of the world in which they live. In phenomenology, researchers interpret how people behave by attempting to see the world from their point of view. As a result, phenomenological researchers must seek to see through the eyes of the research participants as much as possible in order to accurately interpret social interaction. In addition, phenomenology typically relies upon a qualitative research approach (Bryman and Bell, 2011; Creswell, 2009; Strauss and Corbin, 1998).

Therefore, the phenomenological paradigm has been chosen because the study requires interpretation of human behaviour and social interaction, involves qualitative research and primarily addresses how and why phenomena occur. However, to understand how and why phenomena occur, what phenomena are occurring is also addressed. Phenomenology is a more holistic approach than positivism because it is able to provide rich explanation and understanding of multiple complex phenomena (Bryman and Bell, 2011; Creswell, 2009). As a result, the phenomenological paradigm is appropriate for answering the research question in the proposed study.

From the beginning, Prahalad and Hammond (2002) and Prahalad and Hart (2002) followed a phenomenological approach in order to describe the business and social complexities encountered when developing strategy to reach the BoP market. Further, the phenomenological paradigm has been adopted pervasively throughout the literature because the research being conducted on the BoP market tends to be rich and descriptive (London, 2005; London et al., 2010; Prahalad, 2010; Simanis, 2010, 2012; Simanis and Hart, 2006; Viswanathan et al., 2009; Weidner et al., 2010). Thus, a significant portion of the literature is focused on understanding and explaining strategies for launching BoP ventures (London, 2009b; Simanis et al., 2008). Consistent with the literature, the current research study is phenomenological in nature in order to develop a holistic understanding and description of impact assessment of a BoP venture in Afghanistan.

Second, at the analysis level, a primarily qualitative, inductive approach to research has been chosen, which is in line with the phenomenological paradigm. Qualitative research has a greater potential to provide descriptive detail and holistic understanding of phenomena compared to quantitative research. It also takes a more

holistic view and is better suited to deal with a higher level of subjectivity. Further, qualitative research is both interpretivist and constructionist, which means the social world is understood through interpretation of its participants and social properties are outcomes of the interactions between individuals (Bryman and Bell, 2011). Thus, qualitative research is appropriate because the research study relies upon understanding both economic and social dynamics within various communities.

Conducting a qualitative study is relevant where theory (or some other broad explanation) is generated from the raw data. This forms an inductive process of building from the data to broad themes to generalisations or theories. The logic of this inductive approach forms a foundational research process for the current research study and is illustrated in the following figure.

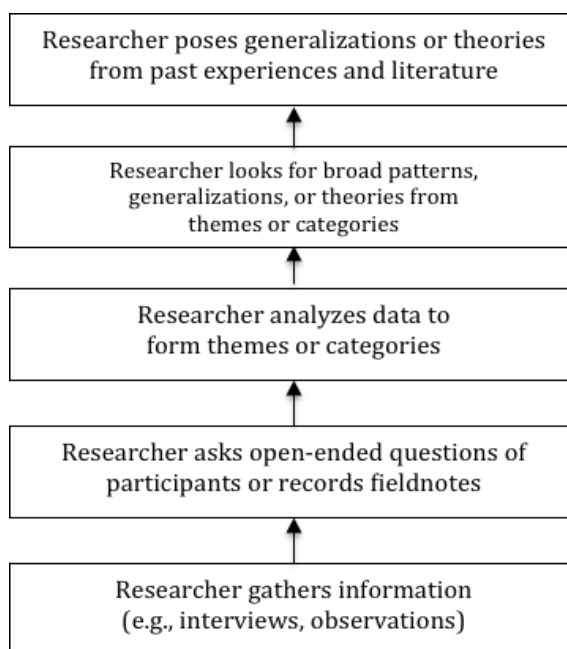


Figure 3.1: Qualitative Studies – Inductive Process (SOURCE: Creswell, 2009)

In this process, the researcher begins by collecting detailed data from participants and then organises the information into themes and categories. The themes or categories are developed into broad patterns, generalisations or theories that are compared to existing literature on the topic, which suggests varied end points for the qualitative studies (Creswell, 2009; Punch, 2005).

Further, inductive research relies more on empirical observation and description of phenomena compared to the deductive approach, which depends primarily upon inferences and developing a chain of logic. In the BoP literature, qualitative, inductive research is prolific, and results are predominantly indicative (Anderson and Markides, 2007; Prahalad, 2002, 2010; Prahalad and Hammond, 2002; Prahalad and Hart, 2002;

Seelos and Mair, 2007; Simanis and Hart, 2006; Wheeler et al., 2005). Therefore, a qualitative, inductive approach has been adopted to most effectively address the proposed research question, aim and objectives and to maintain consistency with the literature.

Third, at the operational level, the timeframe for the overall research study is one year. However, the empirical research was conducted during an extensive field visit to Afghanistan during May-June 2013. Beyond the resources available through Heriot-Watt University, the researcher is employed at a private university and therefore has access to organisational tools and resources such as library databases, specialised software and research grant funding. Additionally, Morning Star Development provided access to human and organisational resources in Afghanistan necessary to complete the research study.

Finally, at the candidate level, the current research strategy complements the researcher's experience and capabilities. The researcher spent two summers interning in Afghanistan during graduate studies, and as a result, is familiar with the safety, business and cultural issues regarding living and working in the country. Later, while a business faculty member at a private university, the researcher was involved in designing and leading international development projects for students in various countries including Benin, Guatemala, Kenya, India, Morocco and Senegal. Developing and facilitating the international projects included conducting background work and research. For example, in one development project, field surveys were administered and interviews were conducted during an empirical, field-based research study in Kenya.

3.3 RESEARCH METHODOLOGY

The research methodology comprises four areas including the research approach, the research methods, the research design and triangulation. First, the research approach is a combination of empirical and field-based research. Second, the case study method has been selected as the appropriate research method. Third, the research design is disaggregated into four parts – the unit of analysis, theory development, design quality and types of designs. Finally, triangulation is achieved by relying upon multiple sources of evidence.

3.3.1 The Research Approach

The proposed research study involves on-the-ground impact assessment of an organisation's BoP venture under normal conditions of operation. Therefore, the chosen research approach is a combination of empirical and field-based research. This combined approach is consistent with the literature and appropriate given the researcher's experience. For example, empirical research is one of the primary methodologies used throughout the BoP literature (London, 2005; London and Hart, 2004; London et al., 2010; Prahalad, 2010; Simanis, 2010; Viswanathan et al., 2009).

Field-based research is also a commonly used methodology in regard to research being conducted on BoP ventures (London, 2005, 2009b; London and Hart, 2004; London et al., 2010; Simanis, 2010). Further, the researcher is proficient in this type of approach based upon experience gained while developing and coordinating international development projects. This experience was discussed in the previous section Research Paradigm and Theoretical Framework.

3.3.2 The Research Methods

In regard to the research methods in the study, the case study method is most appropriate. Yin (2009) outlines five main research methods – experiment, survey, archival analysis, history and case study. When deciding which method to use, three conditions should be explored relating to the five methods. The relevance of each condition when deciding which method to use is provided in Table 3 below.

METHOD	(1)	(2)	(3)
	Form of Research Question	Requires Control of Behavioral Events?	Focuses on Contemporary Events?
Experiment	how, why?	yes	yes
Survey	who, what, where, how many, how much?	no	yes
Archival Analysis	who, what, where, how many, how much?	no	yes/no
History	how, why?	no	no
Case Study	how, why?	no	yes

Table 3.1: Relevant Situations for Different Research Methods (SOURCE: Yin, 2009)

According to Yin (2009), the case study method should be used primarily when how or why questions are being used but can also address what questions. This method is also appropriate when the researcher has little control over events and the research emphasis is on real-life, contemporary phenomena. Further, how and why questions are more explanatory and tend to lead to the use of case studies. As mentioned earlier, the proposed research poses what, how and why questions, and it is concerning assessment in a real-life context in which the researcher has no control. Therefore, the primary method is the case study method.

There is support for the case study method in the BoP literature, in which it is used extensively (Anderson and Markides, 2007; London et al., 2010; Prahalad, 2002, 2010; Prahalad and Hammond, 2002; Prahalad and Hart, 2002; Seelos and Mair, 2007; Simanis and Hart, 2006; Wheeler et al., 2005). The case study method is also consistent with the doctoral work of both London (2005) and Simanis (2010), which rely upon empirical, field-based research. Additionally, London (2009b) used case studies to illustrate assessment of BoP ventures.

Yin (2009) further describes three types of case studies – exploratory, descriptive and causal (or explanatory). Exploratory case studies typically answer what questions while causal and descriptive case studies are better suited to answer how and why questions. The difference between causal and descriptive case studies is subtler. The purpose of causal case studies is to explain presumed causal links in real-life interventions. Descriptive case studies, on the other hand, describe, illustrate or enlighten real-life phenomena. In other words, both types of case studies seek to explain phenomena. The research study does not, however, identify presumed causal links. Rather, it describes and enlightens phenomena in a real-life context. Further, although

the research study addresses the questions of what, how and why, the main thrust of the research is on answering how and why questions. Therefore, the appropriate type of case study for the research is the descriptive case study. It is important to note that the research study moves beyond mere description to more complex conceptualisation in order to develop theory, which is discussed later under Data Analysis.

3.3.3 The Research Design

Four main components of research design include the unit of analysis, theory development, design quality and types of designs. The first component of the research design, the unit of analysis, fundamentally defines the case study. Case studies can focus on individuals, small groups, communities, programmes, projects, processes or organisations (Yin, 2009). Further, Yin (2009) notes that case studies can have more than one unit of analysis. For example, in a programme consisting of multiple projects, the programme could be the main unit of analysis. The projects could be subunits of analysis. Similarly, in the current case study, Morning Star Development's Community Centre Initiative (CCI) is the main unit of analysis, and the health clinic, a BoP venture, is the subunit of analysis. This is what Yin (2009) calls an embedded design, which is discussed further below.

Second, theory development is a critical component of the research design of a case study. Regarding development of theory in the research study, it is first important to define what is meant by the term theory. It can be generally defined as an explanation of observed regularities (Bryman and Bell, 2011) or broad explanation for behaviour and attitudes (Creswell, 2009). Theory can be more specifically defined as a set of categories (e.g., themes, concepts) that are systematically interrelated through statements of relationship to form a theoretical framework that explains certain phenomena (Strauss and Corbin, 1998). Further, theory is something that can both influence and guide the collection and analysis of data as well as occur after the collection and analysis of some or all of the data (Bryman and Bell, 2011). Thus, theory in the current research study refers to an explanation of observed regularities (e.g. occurrences, behaviours) that has been formed into a framework that explains the phenomena.

Understanding the various definitions of theory and how the term is used in the current research is important because a case study can either develop new theory or test existing theory. This is dependent upon whether theoretical frameworks can be found in the existing literature base. Where existing frameworks are available, this can provide a

rich background or general blueprint for designing the case study and testing an existing theory (Yin, 2009). Bryman and Bell (2011) concur that this inductive strategy of linking data and theory is typical of qualitative research, and that theory is often used as a background in qualitative studies. Subsequently, once the theory has been inductively developed, it can be compared to existing literature on the topic (Creswell, 2009; Punch, 2005). It is important to note that relying upon an existing theory is a common characteristic of the deductive approach. However, this tactic can also inform inductive theory development (Bryman and Bell, 2011).

Thus, although theory development generally relies upon either an inductive or deductive process, the two approaches are not mutually exclusive. As Bryman and Bell (2011) indicate, research is very rarely entirely inductive. Rather, just as deductive research comprises components of induction, inductive research often involves elements of deduction. In fact, research studies often weave back and forth between theory and data. This approach is referred to as an iterative process, and the iteration between data and theory is often crucial for generating theory, especially when using grounded theory as the approach to data analysis.

Therefore, although the approach to theory development in the current research study is primarily inductive, it also entails minor elements of deduction. For instance, the current study relies upon the BoP Impact Assessment Framework (existing theory) as a rough theoretical framework (deductive element) to inform initial case study design. However, the overall research process is inductively driven, which results in the development of theory from the raw data. Once the theory is inductively developed, it is later compared against the framework. Thus, the research study leverages a primarily inductive theory development process, in combination with a modicum of deduction, to test, elaborate and extend an existing theory. Further, iteration between theory and data is essential to developing theory in the study. The theory development process is discussed in more depth under the Data Analysis section below.

The same theoretical orientation is used to generalise results of the case study. This means generalisation is not attempted through the more common statistical generalisation because the case study is not a sampling unit. Rather, generalisation from the case study results is achieved through analytical generalisation. This type of generalisation relies upon an existing theoretical framework with which to compare the empirical results (more specifically, the inductive theory generated by the raw data) of the case study. In analytical generalisation, the researcher seeks to generalise a particular set of results, or theory, developed through case study research to some

broader theory (Yin, 2009). Therefore, the BoP Impact Assessment Framework not only facilitates data collection and theory development, but it is also used as a theoretical template with which to generalise empirical results (inductive theory) of the case study.

Third, Yin (2009) summarises four tests with corresponding tactics for ensuring the quality of research design. Design quality is impacted by construct validity, internal validity, external validity and reliability. Three tests are pertinent to the research design of the proposed case study – construct validity, external validity and reliability. Internal validity is not relevant because it is used for causal case studies only and not for descriptive or exploratory studies (Yin, 2009). Therefore, specific tactics are incorporated in order to address the three relevant tests and ensure research design quality.

A major complaint in regard to construct validity is that subjective judgements are made to collect data in case study research (Yin, 2009). Therefore, in order to increase construct validity, multiple sources of evidence are used in the case study with data converging in a triangulating manner on the same facts and findings. Yin (2009) describes six possible sources of case study evidence – documentation, archival evidence, interviews (including focus groups), direct observations, participant-observation and physical artifacts. He notes that the various sources are complementary, and a good case study should include numerous sources. Consequently, the current case study incorporates documentation, archival evidence, direct observations, interviews and focus groups as sources of evidence. Multiple sources of evidence are expounded further within the following sections Triangulation and Sample Selection and Data Collection.

The second test regarding research design quality is the test of external validity. This test deals mainly with whether or not the case study findings are generalisable (Yin, 2009). Generalisation has already been discussed within this same section regarding theory development. As mentioned previously, the case study is not a sampling unit. Therefore, statistical generalisation is not relevant. Rather, analytical generalisation is used in the current case study research to generalise the results (inductive theory) in regard to an existing theory – the BoP Impact Assessment Framework.

The test of reliability emphasises minimising errors and biases during case study research. In essence, the objective of reliability is developing a set of procedures that enable the researcher to conduct the same case study multiple times with the same results and conclusions (Yin, 2009). Therefore, a set of procedures for collecting data

has been developed to increase reliability. The data collection procedures are illustrated below in the following section Sample Selection and Data Collection. In addition, data analysis procedures have been implemented during and after data collection in order to increase reliability. These grounded theory procedures are discussed later in the section Data Analysis.

Finally, Yin (2009) describes four main types of case study design – single-case (holistic) design, single-case (embedded) design, multiple-case (holistic) design and multiple-case (embedded) design. The various designs are illustrated in Figure 3.

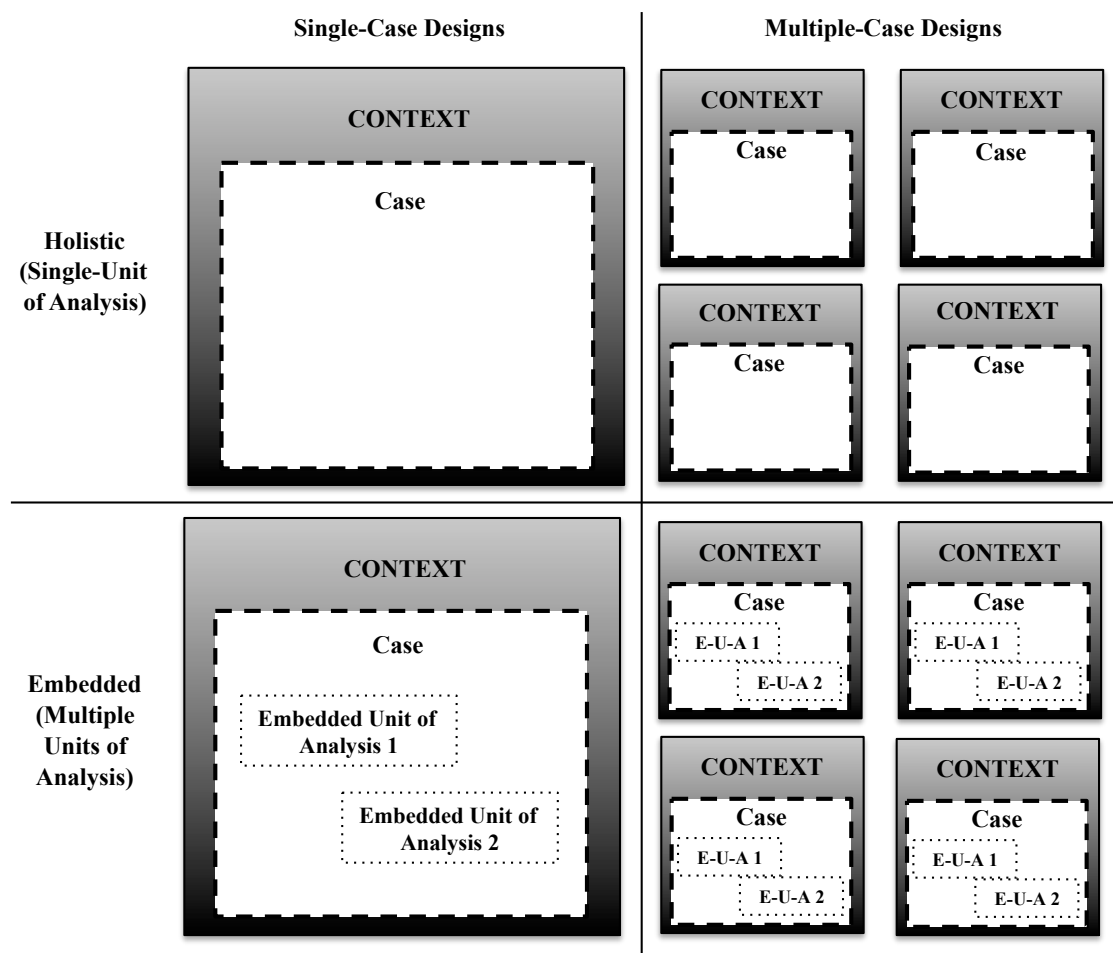


Figure 3.2: Basic Types of Designs for Case Studies (SOURCE: Yin, 2009)

The single-case, embedded design is used for the case study research. According to Yin (2009), there are five potential rationales for choosing a single-case design. The possible rationales include the critical case, the extreme or unique case, the representative or typical case, the revelatory case and the longitudinal case. Descriptions of the various rationales are summarised in Table 4 below.

Rationale for Case	Description
Critical	Tests existing theory
Extreme or Unique	Common in psychology for documenting rare disorders
Representative or Typical	Normal, everyday circumstances or situations
Revelatory	Conditions or situations previously inaccessible or not yet investigated
Longitudinal	How conditions change over time

Table 3.2: Rationales for Single-Case Design (SOURCE: Yin, 2009)

The case is not extreme or unique because it is not related to erratic situations such as instances of a rare disease or syndrome. It is also not a representative or typical case, which investigates common or everyday experiences of the average person or organisation. Further, the case is not longitudinal because it does not aim to measure how conditions change over time.

Therefore, the basis of the case study is a combination of the critical and revelatory rationales. The case study is critical because it tests an existing theory resulting in confirming, challenging, elaborating or extending the theory. However, it is also revelatory because the research is conducted within a context – small rural village communities in Afghanistan – that has not been investigated by BoP researchers. Research in this context is challenging because of the deteriorated security situation, unique social-cultural dynamics and tightly knit village communities.

The case study design is embedded rather than holistic because the organisation involved in the case, Morning Star Development, operates several initiatives and ventures under the broader organisation. Yin (2009) advocates that the holistic design is advantageous when no subunits can be identified. However, the problem with the holistic design is that the entire case study may lack sufficient detail because it is investigated at too broad a level. Therefore, an embedded design is more appropriate for the case study research because of the readily identifiable subunits of analysis. As mentioned earlier, MSDEV's CCI is the larger unit of analysis and the health clinic BoP venture is the primary subunit of analysis. The broader context comprises the small rural village communities in Afghanistan with which the organisation targets the BoP venture. A chart of the organisation's initiatives (Unit of Analysis-Level 1), BoP ventures (Unit of Analysis-Level 2) and context are illustrated in the following figure. The health clinic BoP venture is the embedded unit of analysis, which is the primary focus of the case study.

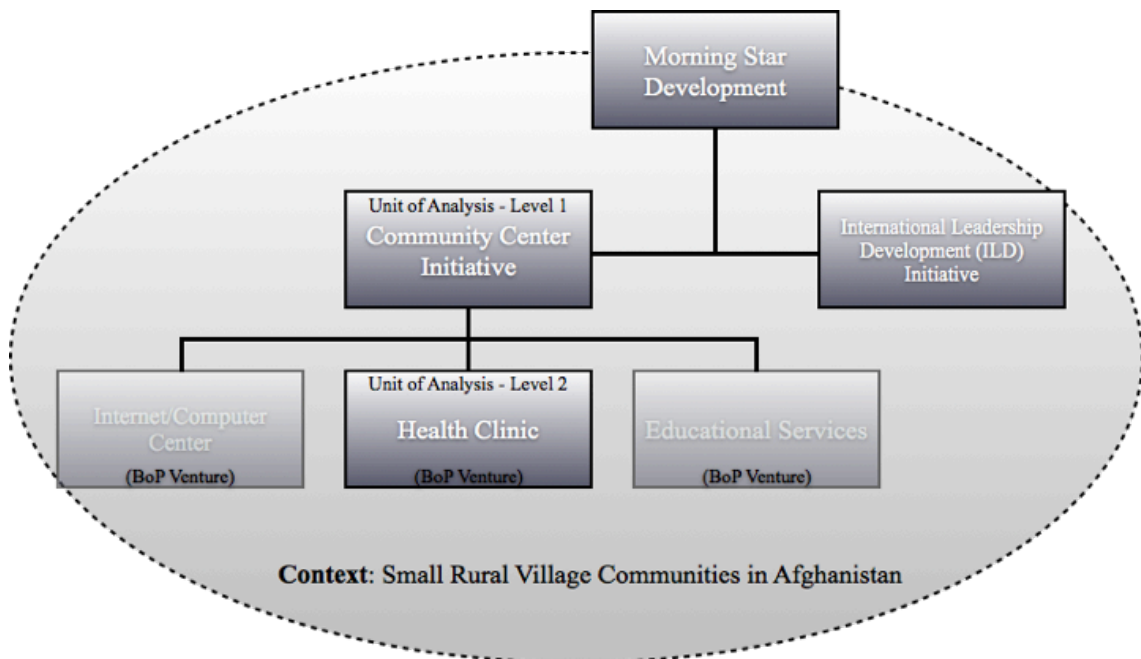


Figure 3.3: Case Study Method – Single-Case (Embedded) Design (SOURCE: Author)

3.3.4 Triangulation

Triangulation is achieved by relying upon multiple sources of evidence within the case study method. Collecting information from multiple sources is aimed at corroborating the same facts or phenomena. Data is considered triangulated when events or facts of the case study have been supported by more than a single source of evidence. In fact, one of the major strengths of the case study method is the opportunity to use many different sources of evidence. Using multiple sources of evidence in a case study allows the researcher to address a broader range of historical and behavioural issues and develops converging lines of inquiry resulting in triangulation of the data. Thus, any case study finding or conclusion is more accurate and credible if it is based upon multiple sources of evidence (Yin, 2009).

As previously discussed, sources of evidence used in the case study include documentation, archival evidence, direct observations, interviews and focus groups. The sources of evidence used in the case study are illustrated in the following figure.

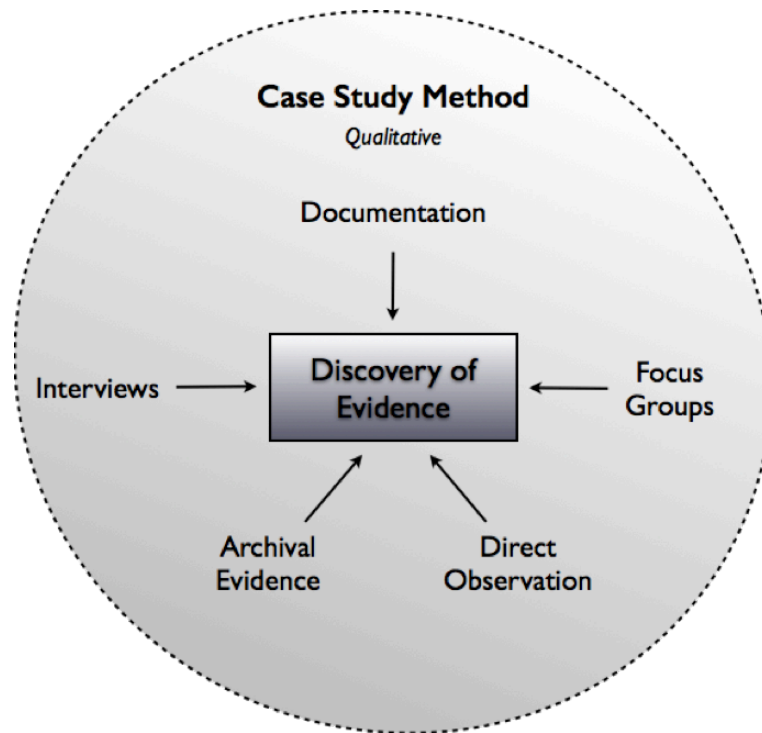


Figure 3.4: Triangulation of Data in the Proposed Research Study (SOURCE: Author)

The multiple sources of evidence applied within the case study method follow a qualitative approach, which delivers a more holistic set of data. Yin (2009) argues that this multipronged approach to research not only results in triangulating the data, but it also helps overcome problems associated with construct validity and reliability. Specific details concerning the actual collection of data from the various sources of evidence is described in the following section Sample Selection and Data Collection.

3.4 SAMPLE SELECTION AND DATA COLLECTION

Several areas are discussed concerning the sample selection and collection of data. First, the organisation used in the case study is reviewed. Second, the approach to sampling is discussed. Third, the case study instrument is expounded. Finally, details of the data collection process are outlined and broken down into three stages. Included within the various stages of the data collection process is a description of how the multiple sources of evidence were implemented.

3.4.1 Organisational Description

Morning Star Development is a non-governmental organisation (NGO) that was incorporated in 2002 under U.S. 501(c)3 non-profit status, and it began operations in Afghanistan the same year. The organisation employs more than 200 employees. This employee count includes a small office in Colorado Springs, Colorado with about 7 core staff members, and the rest of the employees are located in Afghanistan. Their website can be found at the following web address www.msdev.org.

Morning Star Development's purpose is to help the people of Afghanistan rebuild their country and their lives through sustainable economic and community development initiatives. The initiatives are designed to empower individuals and transform communities throughout Afghanistan. MSDEV has developed two main initiatives – the Community Centre Initiative (CCI) and the International Leadership Development Institute (ILD). The community centres are designed to bring critical services to Afghans living in rural village communities throughout the country. The CCI is the main unit of analysis in the case study. The ILD targets urban professionals aspiring to become leaders within their respective field of work. This initiative is not incorporated as part of the case study.

MSDEV currently operates three community centres of varying levels of development. The first is located in Tangi Saidan, which is a village near Kabul, Afghanistan. This is organisation's longest standing and most developed community centre. It has been in operation for about 10 years, and the organisation has launched three BoP ventures from this site. This is the site that is included in the case study. The second and third community centres are located in Lalandar and Jegdalek, respectively. Tangi Saidan was chosen for the research study because it is more established and accessible than the other community centres. Lalandar was not chosen because it only serves 3,000 people, and it is more remote compared to Tangi Saidan. Further, due to

proximity with the border of Pakistan and subsequent security risk, Jegdalek was not included in the case study.

The community centres act as a beachhead or a type of regional headquarters from which the organisation can engage the surrounding communities as well as launch various BoP ventures aimed at delivering services to the villages. One of MSDEV's BoP ventures, the health clinic, is evaluated using the BoP Impact Assessment Framework. This venture is launched from the community centre in Tangi Saidan. The health clinic targets the surrounding region, which includes a total of 39 villages and a population of approximately 16,000. This BoP venture is the subunit of analysis, and it is the primary focus of the case study research.

3.4.2 Sampling Approach

As previously mentioned, a case study concerning a single organisation was chosen to effectively address the research question, aim and objectives. Consequently, a statistical sample was not appropriate for data collection because a case study is not a sampling unit. Instead, a theoretical approach to sampling was applied. Glaser and Strauss (1967) state that the purpose of statistical sampling is to obtain accurate evidence on distributions of people among categories. Statistical sampling is not appropriate for qualitative research due to its reliance upon statistical rather than theoretical criteria. Therefore, theoretical sampling is more appropriate for the research study. Theoretical sampling is a process of developing theory in which the researcher collects, codes and analyses data. According to Bryman and Bell (2011), emerging theoretical considerations guide actual data collection such as the selection of cases or research participants. This means that theoretical sampling is an ongoing process compared to a defined statistical sample.

Strauss and Corbin (1998) suggest theoretical sampling requires that the researcher maximise opportunities to discover variations among concepts and densify categories in terms of their properties and dimensions. Thus, in theoretical sampling, the researcher develops theory by discovering categories and their properties. In addition, Glaser and Strauss (1967) advocate that part of the process of developing theory in theoretical sampling includes defining interrelationships between categories and their properties. The researcher must continually decide what data to explore next and where to find the data in order to develop the theory throughout the data collection process. Thus, the data collection process should be guided by theory as it emerges.

One final important feature of theoretical sampling is that it emphasises theoretical reflection concerning data as the guide to whether or not additional data collection is needed. Data collection should continue until theoretical saturation has been reached. Theoretical saturation is the point when emerging concepts have been fully explored and no new theoretical insights are being generated. Thus, theoretical saturation regarding data collection implies that, once a concept or category has been developed, researchers may continue collecting data until a point is reached where new data no longer illuminate the concept or category. Consequently, when the major categories have been saturated, there is little reason to continue data collection (Bryman and Bell, 2011).

Theoretical sampling was the sampling approach used during data collection in the case study research. The bulk of data was collected during Stage II of the data collection process (discussed below in the section Details of the Data Collection Process). As data was collected, it was concurrently coded and analysed. Themes and categories naturally emerged and interrelationships were explored and defined. During the data collection process, the researcher engaged in theoretical reflection concerning data in order to decide what data to explore next, to determine where to find the data and to guide whether or not additional data collection was needed. Data collection ensued until theoretical saturation was reached throughout all categories.

3.4.3 Case Study Instrument

The case study instrument is the primary data collection tool used within the case study method. Questions developed for the case study instrument were adapted from the literature (development reports, health questionnaires, theses, etc.) and contextualised to the local situation in Afghanistan with input from MSDEV executive staff. This is consistent with the approach followed by London (2009b), in which he based some assessment questions on previous surveys developed by organisations such as the World Health Organisation while other questions were contextualised to the local environment.

According to Yin (2009), there are two characteristics that distinguish the case study instrument from other instruments such as survey questionnaires. The first characteristic is the general orientation of questions. Whereas structured survey questions are all posed to the interviewee, general case study questions are typically aimed at the investigator. Thus, the case study questions form the structure of the

inquiry and are not all intended as literal questions that must be asked of any given interviewee.

The case study questions act as a guide and keep the investigator on track during interviews. Essentially, the case study questions are reminders of what data needs to be collected as well as the purpose for which it is being collected (Yin, 2009). Therefore, in the current case study, the questions on the case study instrument guided the interviews and focus groups with executives and managers at the U.S. and Afghanistan headquarters and employees and other local Afghan stakeholders at the Tangi Saidan health clinic. The case study questions also facilitated addressing the *how* and *why* questions in regard to the research question, aim and objectives.

The second characteristic that differentiates the case study instrument from other instruments such as survey questionnaires is the levels of questions. Yin (2009) illustrates five levels of questions. The following table highlights the five levels with the corresponding types of questions.

Level	Type of Question
1	Aimed at interviewees
2	Aimed at individual case (to be answered by the investigator)
3	Directed at discovering patterns across multiple cases
4	Aimed at an entire study (could be mixed methods study)
5	Normative questions concerning policy and conclusions

Table 3.3: Five Levels of Questions (SOURCE: Yin, 2009)

Level-1 questions are directed at individual interviewees. Alternatively, Level-2 questions are the inquiries that an investigator is attempting to answer through the case study rather than those questions specifically posed to the interviewees. Survey questionnaires are entirely composed of Level-1 questions targeted at interviewees. The case study instrument, on the other hand, can include any combination of the various levels of questions. Therefore, Yin (2009) stresses that investigators must clearly distinguish among the different levels.

Yin (2009) further emphasises that the investigator should concentrate on Level-2 questions for the case study instrument. He also warns against confusing Level-1 and Level-2 questions because investigators tend to mistake questions of inquiry (Level-2) with actual questions that are asked on the field (Level-1). Consequently, Level-2 inquiries must be at the forefront of the investigator's mind while simultaneously articulating Level-1 questions to interviewees. On the case study instrument, both

Level-1 and Level-2 questions are included. However, Level-2 questions form the core of the instrument and represent the most significant inquiries for addressing the research question, aim and objectives. For example, there are four sections of questions on the instrument – services, economic impact, social impact and general questions. The first and fourth sections are composed of Level-1 questions while the second and third sections are composed of Level-2 questions. The case study instrument is included in Appendix 1.

3.4.3 Details of the Data Collection Process

As previously discussed, Yin (2009) advocates working with multiple sources of evidence. Collecting data from multiple sources of evidence allows the researcher to address a broader range of issues and develops converging lines of inquiry resulting in triangulation. In addition, case study findings are more accurate and credible if data is based upon multiple sources of evidence. However, due to the need to integrate real-world events with data collection from the various sources, field procedures should emphasise major tasks such as gaining access to key interviewees, having sufficient resources, creating a clear schedule for data collection activities and preparing for unanticipated events. Therefore, the data collection process for the current study was separated into three principal stages, and careful procedures were implemented during each stage regarding the collection of data from the multiple sources of evidence.

During the course of the research study, approximately 1,000 pages of data were generated, which comprised researcher notes, research assistant notes in Dari, translated research assistant notes, transcriptions of interviews conducted in English, transcriptions (in Dari) of interviews and focus groups conducted in Dari and the translated transcriptions (into English) of interviews and focus groups conducted in Dari. All interviews and focus groups were recorded, resulting in a compilation of around 40 hours of audio. Further, the interviews and focus groups conducted in Dari required translation, and the translations (which provided quotations for the thesis) are not a word-for-word translation in order to be appropriately understood in English. However, the direct quotes were not worded into perfect English in order to preserve the integrity of what was being communicated (Bryman and Bell, 2011; Xian, 2008).

In addition, gender, cultural and religious sensitivity was important during the field research. For instance, focus groups were conducted with female customers (as opposed to interviews) due to the nature of several topics of questions including birth control, breastfeeding and delivery. In discussions with MSDEV, a focus group was

regarded as more gender and culturally appropriate compared to a one-on-one interview with a female customer from one of the villages served by the health clinic. Further, questions were not directed toward any single female, but rather to the group. Women discussed among themselves, and several would respond in Dari to the various questions. The research assistant would then translate into English to the researcher, and the entire event was audio recorded for subsequent transcription and translation.

3.4.3.1 Stage I

During the first stage, organisational documents and archival evidence were collected and examined, which also served as part of the literature review. Yin (2009) suggests examining documents and archival evidence as thoroughly as possible as part of the data collection process. He provides many examples of documents and archival evidence that may be included in the research. Various examples of documentation and archival evidence are summarised in the following table.

Source of Evidence	Examples
Documentation	<ul style="list-style-type: none"> • letters, memoranda, e-mail correspondence, and other personal documents, such as diaries, calendars, and notes; • agendas, announcements and minutes of meetings, and other written reports of events; • administrative documents-proposals, progress reports, and other internal records; • formal studies or evaluations of the same "case" that you are studying; and • news clippings and other articles appearing in the mass media or in community newspapers.
Archival Evidence	<ul style="list-style-type: none"> • public use files such as the U.S. census and other statistical data made available by federal, state, and local governments; • service records, such as those showing the number of clients served over a given period of time; • organisational records, such as budget or personnel records; • maps and charts of the geographical characteristics of a place; and • survey data, such as data previously collected about a site's employees, residents, or participants.

Table 3.4: Examples of Documentation and Archival Evidence (SOURCE: Yin, 2009)

Primary documentation collected in Stage I of the data collection process includes e-mail communication, organisational correspondence with the Afghan government, reports, proposals and meeting notes. Archival evidence collected includes statistical data from US and Afghanistan government sources, health clinic activity reports, budgets, training manuals, past surveys and geographical maps of the region surrounding the health clinic. The documentation and archival evidence that was

collected in Stage I established an important foundation for the interviews, focus groups and direct observations carried out in the second stage.

Financial resources were secured and all logistics were coordinated during Stage I of the data collection process. Logistics were coordinated with MSDEV staff in the U.S. and Afghanistan and included developing an interview schedule, creating a research budget and hiring a research assistant. Resources were secured through grants that covered all related expenses regarding the field-based research. The case study instrument was also developed from the literature review during the first stage of the data collection process. Stage I took approximately six months to complete, and it was crucial for developing a contextual understanding of the situation in Afghanistan, grounding the empirical, field-based research in the literature and planning and organising the research schedule for implementation during Stage II of the data collection process.

3.4.3.2 Stage II

The second stage of the data collection process lasted six weeks and took place during May-June of 2013. This empirical, field-based research formed the core of data collection for the case study and was implemented on the ground in Afghanistan. The second stage primarily included conducting interviews, facilitating focus groups and making direct observations. However, compilation of documentation and archival evidence continued during this stage. Yin (2009) contends that interviews are one of the most important sources of case study information. He further states that observations should take place in the natural setting of the case and can be made while other evidence, such as interviews, is being collected. Therefore, direct observations were made intermittently in the same settings in which interviews and focus groups were conducted.

Direct observations included management interaction with employees, organisational meetings, employee interactions with customers, customer behaviours and normal organisational operations. Interviews, focus groups and observations were conducted from one of Morning Star Development's offices in Kabul as well as the community centre in Tangi Saidan. Interviews and focus groups were conducted in Dari and English with the help of an Afghan research assistant. The research assistant acted as a translator and provided guidance regarding cultural issues and local customs and traditions.

According to Bryman and Bell (2011), conditions sometimes necessitate an intensive approach to interviewing. This means interviews or focus groups are carried out over a short period of time, or a single day. The intensive approach may be required especially where travel is necessary to complete interviews or focus groups. Conducting all interviews in a single day may be necessary given time and resource constraints, but the quality is often higher when there is more time to pilot or pre-test questions. However, the authors note that building relationships with interviewees beforehand may help facilitate completing interviews in a relatively short time period.

The intensive approach to interviewing was an important consideration for the case study research because travel was necessary and time and resource constraints were concerns. To conduct interviews and focus groups with all relevant stakeholders, it was estimated that it would take approximately three weeks given the context and culture in Afghanistan. Internal stakeholders that participated in interviews and focus groups included MSDEV executives, management, residency staff, current medical staff and past medical staff. External stakeholders included community health workers, village elders, health shura members, and customers.

Although the estimated timeframe for completing research was three weeks, the actual research schedule was doubled to six weeks to account for pre-testing and revising case questions as well as encountering security problems, bottlenecks and other unforeseeable events. In addition, the researcher had built relationships with several MSDEV executives over the previous eight years, and interviews with executives took place before, during and after the six-week, field-based research in Afghanistan. Therefore, though it was relatively intensive, the six-week research schedule included ample time to complete all interviews, focus groups and direct observations.

The interviews were exclusively qualitative, which is consistent with the phenomenological paradigm and theoretical framework of the research study. In qualitative interviews, the interviewee's point of view is of particular interest, and it is common for the investigator to pursue tangents in order to gain insight into the interviewee's views and beliefs. Interviewers can depart from the instrument or guide that is being used and can ask new or follow-up questions to interviewee replies. They can also vary the order and wording of questions. Qualitative interviews tend to be flexible and respond to the direction the interviewee takes the interview, and the emphasis in each interview may vary depending upon the pertinent issues that arise during the interview. Interviewees may even be interviewed multiple times on different

occasions when appropriate. Ultimately, qualitative interviewing was crucial for the case study research because it produced rich, detailed data (Bryman and Bell, 2011).

All qualitative interviews conducted as part of the field-based research were semi-structured. Moreover, some of the semi-structured interviews were focused interviews while others were in-depth interviews. In a semi-structured interview, the researcher has a list of questions covering a range of topics often referred to as an interview guide or case study instrument. Questions may not exactly follow the outline of the instrument, and the interviewee has significant latitude concerning how to reply. As a result, the interviewer may ask questions that are not on the instrument depending on the answers the interviewee provides. However, all questions are asked and a similar wording is used across all interviews. The interview process in semi-structured interviews is therefore flexible (Bryman and Bell, 2011).

Further, Yin (2009) suggests that researchers rely upon both focused and in-depth interviews in case study research. Both types of interviews resemble more of a guided conversation than a structured query. In a focused interview, a person is interviewed for a shorter, identified amount of time. Although this type of interview remains open ended and conversational, the interviewer follows a set of questions from the case study instrument in order to maximise the limited time with the interviewee. Interviews with most participants in the case study were semi-structured, focused interviews. However, several informants were identified. An informant goes beyond the normal expectation of a typical interviewee by providing superior insight into matters or initiates access to additional sources of evidence during the case study (Yin, 2009).

Thus, the semi-structured, in-depth interviews were primarily conducted with the informants. Compared to the focused interview, the in-depth interview may take place over an extended duration of time rather than a predetermined time period. It is more like an ongoing discussion than a single interview. This type of interview is beneficial because it not only can produce rich information, but it may also result in future discussions with new interviewees as well as leads to other sources of evidence. Incorporating the in-depth interviews and identifying key informants is important because Yin (2009) indicates that in-depth interviews with key informants are often critical to the success of a case study.

Focus groups were conducted in addition to the individual interviews in Afghanistan for several reasons. First, according to Bryman and Bell (2011), most focus groups are qualitative in nature and reveal how group participants view the issues with which they are confronted. Focus groups enable researchers to interview groups of

people about experiences in a relatively unstructured way, and the technique allows researchers to understand why people feel the way they do. Thus, in the case study, focus groups were important to develop comprehensive understanding concerning *how* and *why* phenomena had occurred.

Second, participants discuss issues as members of a group rather than merely as individuals in focus groups. For example, if an individual provides a particular answer in a focus group, he or she may later modify the response as others contribute to the discussion. Participants may encourage or agree with one another or even challenge each other's views. In fact, the process of discussion, and even arguing, often results in a more realistic account of what participants actually believe because they are forced to think and possibly revise their views. Therefore, focus groups provide the opportunity to study the way individuals collectively make sense of phenomena (Bryman and Bell, 2011). Enabling a level of collective discussion and social interaction through focus groups was important during the field-based research due to the collective nature of the Afghan culture.

Finally, Bryman and Bell (2011) suggest that a diverse range of stakeholders is commonly included in focus groups, and they are often organised into separate groups based upon stratified criteria such as age, gender, occupation or hierarchical position. One of the benefits of this type of focus group is the ability to explore collective understanding or shared meanings held by members within a particular group. This was a significant point of interest concerning the case study research in Afghanistan. For example, groups within the Afghan village communities such as community health workers or health shura members have access to privileged knowledge and often share similar viewpoints based upon membership in their respective groups. Therefore, including focus groups as a source of evidence provided insights into unique perspectives held by various groups.

Overall, the second stage of the data collection process comprised the core of the empirical, field-based data collection, which included interviews, focus groups and direct observations. Qualitative, semi-structured interviews were the most significant source of case study information. Many of the semi-structured interviews were focused interviews while others were in-depth interviews. Focus groups were also included as empirical sources of evidence in the case study in order to enhance understanding of how and why phenomena occurred, engender social interaction and study viewpoints of various groups. Direct observations were made intermittently in the same settings in which interviews and focus groups were conducted, and data collection from

documentation and archival evidence continued in the second stage. Finally, data was collected from the multiple sources of evidence until theoretical saturation was reached.

3.4.3.3 Stage III

The third stage of the data collection process was crucial for generating the necessary data for subsequent analysis, and there was some overlap between the second and third stages. For example, field notes based on participant answers and direct observations were taken by the researcher and the research assistant during interviews and focus groups. All interviews and focus groups were recorded for subsequent transcription and translation. Therefore, the final stage of data collection included the translation of field notes and the transcription and translation of audio files. There were three general phases of transcription and translation. First, the research assistant translated his field notes from Dari to English, which overlapped with the second stage of data collection. Second, the researcher's teaching assistant in Oklahoma transcribed audio files from interviews and focus groups conducted in English. Finally, audio files from interviews and focus groups conducted in Dari were transcribed in Dari and translated into English.

According to Heritage, cited in Bryman and Bell (2011), recording and transcribing interviews has many advantages. For instance, recording and transcription enables the researcher to overcome the natural limitation of what can be recalled from an interview, and it helps prevent possible biases that researchers might place on what people say during interviews. It also facilitates more thorough examination of what people say. Further, recording and transcription allows multiple examinations of answers given by interviewees. Therefore, this final stage was crucial to ensure a rigorous data collection process by thoroughly capturing qualitative data, minimising errors, reducing bias and providing a clear basis for conducting subsequent data analysis.

Bryman and Bell (2011) indicate that one of the challenges regarding transcription is that it is very time consuming. It can take five to six hours to transcribe one hour of audio. Additionally, they suggest a second challenge is that a large amount of data is produced through transcription. In fact, this has been true in the current case study research as transcription has yielded several hundred pages of data. The time factor in the current case study was further exacerbated by the need for translating transcriptions from interviews conducted in Dari. However, translation is becoming increasingly common as more business and management research is conducted from

international or cross-cultural perspectives. This raises potential language and translation problems associated with data collection in a language other than English and then translating it into English.

For example, Xian (2008) suggests that translation requires a construction of social realities in a different language. This poses unique research challenges, and there are linguistic, social-cultural and methodological issues associated with translating interview data. Linguistic challenges arise when interviewees use words for which there is no equivalent in English, or grammatical structures cannot be easily translated. Social-cultural difficulties include translating idioms or proverbs from one language to another that rely on socio-historical knowledge to understand. Methodological challenges result because the translator imposes his or her authority on a foreign culture.

Therefore, Xian (2008) concludes that translation is a sense-making process that involves the translator's knowledge, social background, and personal experience. She further recommends that researchers and translators acknowledge and work with the difficulties associated with translation. Researchers should not ignore silences, or things in one language that do not have an equivalent in other languages, and work out inconsistencies between the source and target cultures. Subsequently, translators and researchers should not be deterred by these cultural differences or inherent translation challenges. Rather, they should strive to preserve and highlight cultural differences because these disparities enrich cross-cultural research. Thus, to address the challenges regarding translation, the researcher worked closely with the research assistant/translator and other informants to understand key definitions of Dari words, social-cultural meanings regarding Afghan culture and differences between the source and target cultures.

In summary, the data collection process involved three stages. Organisational documents and archival evidence were collected and examined in the first stage of the data collection process. The data that was collected in Stage I established the foundation for the interviews, focus groups and direct observations carried out in the second stage. Stage II of the data collection process comprised the core of the empirical, field-based data collection, which included interviews, focus groups and direct observations. In addition, documentation and archival evidence were also collected during the second stage where appropriate. The bulk of the qualitative data was collected during this stage. The third stage of the data collection process (which slightly overlapped with the second stage) involved the translation of field notes and the transcription and translation of audio files. This final stage was necessary to prepare all data for analysis, which is

discussed in the following section. The stages of the data collection process are summarised in the table below.

Stages of Data Collection	
Stage/Activity	Description of Activity
Stage I	
Documentation	- Collected and examined documentation including e-mail communication, reports, proposals and meeting notes
Archival Evidence	- Collected and examined archival evidence including statistical data, health clinic activity reports, budgets and past surveys
Logistics	- Logistics were coordinated including interview schedule and research budget, and finances were secured through grants
Stage II	
Interviews	- All interviews were qualitative and semi-structured - Focused interviews were conducted with most participants - In-depth interviews were conducted with informants
Focus Groups	- All focus groups were qualitative - Focus groups engendered social interaction and provided insights into viewpoints of various groups
Direct Observations	- Direct observations were made intermittently in the same settings in which interviews and focus groups were conducted
Stage III	
Transcription/Translation	- All research assistant field notes were translated from Dari to English - Audio files from interviews and focus groups conducted in English were transcribed - Audio files from interviews and focus groups conducted in Dari were transcribed in Dari and translated into English

Table 3.5 Summary of the Stages of the Data Collection Process (SOURCE: Author)

3.5 DATA ANALYSIS

3.5.1 Qualitative Data Analysis

Qualitative data from sources such as interviews or focus groups typically results in a significant amount of data, which is often cumbersome to analyse. The large database usually takes the form of field notes, interview transcripts and other documents. Miles (1979) referred to qualitative data as an attractive nuisance because it produces rich data but analysis is highly labour-intensive. Thus, the data analysis process can be stressful and overwhelming due to the scope of phenomena that may be observed, the sheer volume of field notes and transcriptions and the time required for write-up, coding and analysis.

Further, clear rules about how qualitative data analysis should be carried out have not been developed. Quantitative data analysis techniques, on the other hand, provide a relatively unambiguous set of rules concerning how to analyse the data. Quantitative data must still be interpreted, but there are at least fairly clear rules for analysis. Although qualitative data analysis has not reached the level of systematised procedures found in quantitative data analysis, this is not necessarily desirable in qualitative research. However, general approaches for qualitative data analysis are available that provide broad guidelines that should be followed (Bryman and Bell, 2011).

3.5.2 Grounded Theory

One of the general approaches to qualitative data analysis is referred to as grounded theory. Grounded theory was first articulated by Glaser and Strauss (1967; pg. 2) as ... *the discovery of theory from data systematically obtained by social research*. They suggest that grounded theory is an appropriate fit for empirical situations, is easily understood by both researchers and the general public and provides relevant explanations and interpretations of phenomena. Strauss and Corbin (1998) more recently describe that grounded theory is derived from data that was systematically collected and analysed through the research process, and that data collection, analysis and theory are closely related to each other. Consequently, grounded theory represents an iterative process because data collection and analysis are carried out concurrently. Further, Glaser (2001) states that all is data regarding grounded theory research. This means that everything related to the research study is data – whatever the source. Thus, in grounded theory, many sources of evidence are regarded as relevant data for analysis such as documentation, interviews and observations.

According to Bryman and Bell (2011), grounded theory has become the most widely used general approach for analysing qualitative data. Glaser (2010) suggests that one reason grounded theory has spread so rapidly is due to globalisation. Globalisation has accelerated due to advances in communication, business and travel. As a result, diversity has impacted research in many areas including business, health and education. Methods that are more formulated and evidentiary work well in homogenous environments. However, grounded theory is effective where cultural diversity is present as it allows the researcher to understand realities beyond his or her cultural view. Thus, grounded theory is appropriate for field-based research conducted in cross-cultural contexts.

Some researchers have narrowly defined grounded theory as a descriptive qualitative data analysis method such as composing stories or narratives about phenomena. However, grounded theory should not be reduced to a purely descriptive method in which researchers compose a story. Rather, grounded theory is a conceptual approach that generates a theory by careful application of procedures, or processes, that are explained below. When relying upon this approach, researchers must be able to conceptualise data and tolerate confusion and regression. Grounded theory also provides conceptual freedom from time, place and received concepts. As a result, grounded theory requires a discovery process to identify phenomena, and at the same time, provides an openness that enables the generation of concepts that make sense of the phenomena (Charmaz, 2000; Glaser, 2010, 2012).

3.5.2.1 General Procedures

As mentioned above, there are several procedures that comprise grounded theory. First, data collection and analysis are an interrelated process. Analysis begins as soon as the first pieces of data are collected. Commencing data collection and analysis simultaneously is necessary because continual analysis is used to determine and direct subsequent sources of evidence such as documents, interviews or direct observations. This does not mean that data collection is not standardised. Rather, this approach enables the researcher to exhaust all possible sources of evidence that lead to understanding phenomena. Concepts brought into the research study or discovered during the research process are initially provisional. They are eventually incorporated into theory by repeatedly being present in the various sources of evidence. Thus, grounded theory requires discovery and grounds theory in reality (Corbin and Strauss, 1990; Glaser and Strauss, 1967).

Second, sampling is theoretical as opposed to statistical. Theoretical sampling was elaborated on earlier under the section titled Sampling Approach. As discussed, theoretical sampling is not a statistical sample. When a study begins, the researcher has an idea, or framework, of the phenomena to study. Based on this preliminary understanding, the researcher selects an organisation, individuals or community members representative of the phenomena. For example, if a researcher plans to study nurses' work, the individual will visit where the nurse works such as a hospital, clinic or home. The researcher does not sample nurses, but rather the incidents, events or happenings regarding nursing as well as conditions that enable, interrupt or prevent their work. Thus, in grounded theory, theoretical sampling results in representativeness of concepts rather than people (Corbin and Strauss, 1990).

Third, theoretical saturation is directly related to theoretical sampling. It is a process that is associated with both the collection and coding of data. As previously discussed, theoretical saturation is the point when emerging concepts have been fully explored and no new theoretical insights are being generated. This means that no new data seem to emerge in relation to concepts and categories, the concepts and categories are well developed in terms of properties and dimensions and relationships between concepts and categories are well developed and validated. Data collection normally continues until theoretical saturation has been reached. Thus, theoretical saturation regarding data collection implies that researchers continue collecting data until new data are no longer illuminating identified concepts and categories. Once the major concepts and categories have been saturated, there is little reason to continue collecting data or reviewing data for relationships (Bryman and Bell, 2011; Strauss and Corbin, 1998).

Fourth, coding is the central process in grounded theory by which data are broken down into component parts and given labels that correspond with significant phenomena. The purpose of labeling phenomena is to group data under similar headings or classifications. In grounded theory, coding begins alongside data collection and is a crucial first step in generating theory. It is also important that coding remains flexible and fluid in grounded theory. Throughout the coding process, the researcher engages in conceptualisation of the data. Conceptualisation requires the researcher to think abstractly. Thus, it is the abstract interpretations of data and theory development that enable the researcher to assign labels to concepts and categories representing phenomena that have been broken down into ideas, incidents and events. The overall process is comprised of three types, or phases, of coding including open coding, axial coding and selective coding. The coding process is discussed in greater detail in the

following section below (Bryman and Bell, 2011; Corbin and Strauss, 1990; Strauss and Corbin, 1998).

Fifth, in order to properly develop concepts and categories, the analytical process should be recorded by creating memos and diagrams. Memos are specialised written records that contain analysis or direction for the researcher while diagrams are visual devices that illustrate relationships among concepts. Both are essential procedures for conducting analysis in grounded theory. Depending on the research phase and type of coding, memos and diagrams vary in content, length and degree of conceptualisation. However, they should be included throughout the entire coding process. Memos and diagrams function as not only reflections of analytic thought, but also as a storehouse of analytic ideas that can be sorted, ordered and retrieved as theory evolves. Therefore, the contents of memos and diagrams are crucial to theory development (Strauss and Corbin, 1998).

There are several important technical features regarding memos and diagrams. For example, memos and diagrams typically are dated and include other important means of identification such as references and code numbers regarding the source interview, observation or document. In addition, they should contain headings signifying the concepts or categories to which they pertain along with cross-references to other related concepts. Short quotes or phrases of raw data can also be included. If several memos begin to appear similar, then the researcher should compare the concepts for similarities and difference. Additionally, the researcher should indicate on memos when a category appears saturated (Strauss and Corbin, 1998).

Finally, grounded theory analysis makes use of constant comparisons. According to Bryman and Bell (2011), constant comparison refers to a process that maintains a close connection between data and conceptualisation. Glaser and Strauss (1967) state that the purpose of this constant comparative method is to systematically generate theory. This approach includes comparing incidents applicable to each concept or category, integrating categories and their properties, delimiting the theory and writing the theory. Thus, constant comparisons play an integral role in the development of concepts and categories and enable the researcher to generate theory that is close to the data, consistent, integrated and plausible.

Strauss and Corbin (1998) suggest there are two general types of comparisons. The first makes comparisons between incidents at the property level and looks for similarities and differences between their properties in order to structure classification of data. The second type is referred to as theoretical comparisons, which occurs at an

abstract, or dimensional, level. This type of comparison involves comparing concepts or categories. The use of constant comparisons is essential in grounded theory because the procedure allows the researcher to make objective assessments of phenomena instead of classifying data without thorough examination. As a result, the researcher is able to achieve greater precision and consistency regarding data collection and analysis and is better equipped to guard against bias (Corbin and Strauss, 1990).

3.5.2.2 The Coding Process

As discussed above, coding is the fundamental analytic process in grounded theory. Concepts are the basic unit of analysis in grounded theory. The researcher works with conceptualisations of data, which are abstracted from the actual raw data. This is crucial because theories are not a simple description of events or activities. Rather, the incidents, events or circumstances are potential indicators of phenomena, which are given corresponding conceptual labels. It is by comparing ideas and incidents and naming related phenomena with the same term that the researcher develops the basic units of theory. As analysis continues, concepts accumulate and may become more abstract. Concepts relating to the same phenomenon are grouped into categories. Categories are developed at a higher level and are more abstract than the concepts they represent. Categories are generated through the same analytic process as concepts, which involves making comparisons between concepts to highlight similarities and differences. The analysis yields various groups of concepts that form higher order categories, and categories are the cornerstones of developing and integrating theory in the grounded theory approach. As categories become related to one another, they begin to form an integrated, coherent theory (Corbin and Strauss, 1990).

The coding process comprises three basic types, or phases, which include open coding, axial coding and selective coding. First, open coding is the initial analytic process through which concepts are identified from phenomena. Open coding is an interpretive process by which data are broken down into separate groups, closely scrutinised and compared for similarities and differences. Concepts that are conceptually similar, or have related meanings, are subsequently grouped together into categories. It is the discovery and development of concepts and categories that represents the primary focus of open coding. Once a category is identified, the researcher can develop its properties (general characteristics of a category) and dimensions (location of a property along a continuum or range). Thus, open coding is an important first step regarding theory building because it involves conceptualising,

creating concepts and categories and developing categories in terms of their properties and dimensions. Further, the analysis and constant comparisons that occur during open coding enable researchers to reduce subjectivity and bias (Corbin and Strauss, 1990; Strauss and Corbin, 1998).

There are several different approaches to open coding, which include line-by-line analysis, analysing by sentence or paragraph and perusing the entire document. Line-by-line analysis involves close examination of data by phrase and sometimes by word. Line-by-line coding is particularly helpful in the beginning of a study because it enables the researcher to quickly generate and develop concepts and categories. Although it is often the most time consuming form of coding, it is typically the most generative. Analysing by sentence or paragraph allows the researcher to determine the main idea in a sentence or paragraph. This approach can be used anytime, but it is especially effective when the researcher needs to conduct additional coding in relation to previously developed categories. Once line-by-line and sentence (or paragraph) coding has been conducted, the researcher may need to peruse the whole manuscript and look for similarities and differences between entire documents (Strauss and Corbin, 1998).

Second, axial coding is the process of relating categories to their subcategories to form more precise and complete explanations regarding phenomena. The purpose of axial coding is to reassemble data that were broken down during open coding and add depth and structure to developing categories. Although the purpose of axial coding differs from open coding, the researcher does not necessarily conduct them in sequential order. Axial coding does require that categories have been formed, but coding is overall an iterative process (Strauss and Corbin, 1998).

Further, categories are distinguished from subcategories and the relationships are tested against data during axial coding. As previously mentioned, a category represents certain phenomena such as a significant event or incident. A subcategory is also a category, but it does not stand for a specific phenomenon. Rather, subcategories answer questions about phenomena such as how, why, when, where or with what consequences. When researchers address these probing questions, they uncover relationships between categories and relate structure to process. Structure provides context and explains why events occur while process reveals the actions or interactions of people, organisations and communities over time. Therefore, structure uncovers why events occur, and process reveals how people act or interact. Thus, subcategories improve the researcher's ability to explain concepts in greater depth. Although the researcher may not initially be

able to determine which concepts are subcategories and which are categories, the distinction often becomes clearer during the axial coding process (Corbin and Strauss, 1990; Strauss and Corbin, 1998).

Third, selective coding is the process of integrating and refining categories. This type of coding is likely to occur in the later phases of a study. During this process, categories that need additional explanation are further expounded, and all categories are unified around a central, or core, category. By developing a central category, all other categories are integrated to capture the entire story. Thus, the central category represents the dominant underlying phenomenon of the study. It is the main idea presented in the research, and it embodies all action and interaction regarding the study. The central category might emerge from among the categories already identified or a more abstract term may be needed to represent the phenomenon. It is sometimes difficult to decide upon the central category. Sufficient coding often eventually leads to a clear central category. If this does not occur, then the researcher must work at further integration of the analysis (Corbin and Strauss, 1990; Strauss and Corbin, 1998).

Fortunately, there are several techniques that facilitate the integration of concepts and the eventual identification of a central category. The techniques include writing the storyline, moving from description to conceptualisation, making use of diagrams and reviewing and sorting of memos. First, the researcher should attempt to write the storyline, which articulates the main theme regarding the research. This requires that the researcher write several descriptive sentences concerning the research until a story emerges. Once the researcher has written a descriptive story and has a grasp on the essence of the research, he or she must move from description to conceptualisation by identifying a central idea and relating other concepts to the idea. However, diagrams are often more useful than storytelling for conceptualising relationships among concepts. Thus, diagramming can facilitate the integrative process by providing distance from the data and logically illustrating relationships. Finally, memos should be reviewed and sorted because they include clues to integration and are crucial to developing theory.

3.5.2.3 Developing Theory

As previously mentioned, Bryman and Bell (2011; pg. 7) state that the most common meaning of the term *theory* is ... *an explanation of observed regularities*. They further suggest that researchers who follow an inductive research approach often use grounded theory to analyse data and generate theory, and that an inductive strategy of

linking data and theory is typically associated with qualitative research. Strauss and Corbin (1998) use the term theorising to describe the activity of developing theory because it is a complex, lengthy process. Theorising involves conceiving ideas, or concepts, as well as formulating them into a logical, systematic and explanatory scheme. Transforming ideas into theory requires that concepts be thoroughly explored and considered from numerous perspectives. Further, theorising involves making inductions, which are essential for generating concepts, and deductions, which include hypothesising about the relationships between concepts.

Therefore, Strauss and Corbin (1998; pg. 22) define theory as ... *a set of well-developed categories (e.g., themes, concepts) that are systematically interrelated through statements of relationship to form a theoretical framework that explains some relevant social, psychological, educational, nursing, or other phenomenon*. They suggest that the statements of relationship address questions such as who, what, why and how events occur. Ultimately, once concepts are related through the statements of relationship into an explanatory theoretical framework, the research can progress from description to conceptual ordering (organising data) to theory.

After the basic theoretical scheme has been developed, the theory must be refined. Refining the theory involves reviewing the scheme for internal consistency and logic, elaborating poorly developed categories, trimming the theory and validating the theoretical scheme. First, the theory should be reviewed to ensure it is logical and that it does not have inconsistencies. Second, the researcher should increase the density of poorly developed categories. Density within a category has been achieved when all properties and dimensions have been identified and when variations within and across categories have been established (Strauss and Corbin, 1998).

Third, when there is an excess of data, some ideas do not fit the theory. In this case, the peripheral concepts should be dropped. Finally, the theoretical scheme should be validated. This is not the same as validation in quantitative data analysis. Rather, the theoretical scheme represents an abstract interpretation of the raw data in grounded theory. Therefore, the theory should be compared against the raw data to ensure that the abstraction fits with the raw data and that nothing is omitted from the theory (Strauss and Corbin, 1998).

3.5.3 Grounded Theory and the Case Study Method

Grounded theory was the chosen approach to analyse qualitative data generated during case study research for several reasons. First, the case study method relied upon

multiple sources of evidence to generate data including documentation, archival evidence, interviews, focus groups and direct observations. As previously mentioned, Glaser (2001) states that all is data regarding grounded theory research. This means that everything related to the case study is data – whatever the source. Therefore, grounded theory was able to appropriately manage the multiple sources of evidence for analysis. Second, as discussed earlier, grounded theory can be used effectively where cultural diversity is present as it allows the researcher to understand realities beyond his or her cultural view (Glaser, 2010). Thus, grounded theory was appropriate for the empirical, field-based research conducted cross-culturally in Afghanistan. Finally, grounded theory incorporates several key procedures that were essential for analysing qualitative data generated during case study research.

For example, the procedures and tools of grounded theory were leveraged throughout the stages of data collection and continued through data analysis. As previously discussed, data collection and analysis are an interrelated and iterative process in grounded theory (Bryman and Bell, 2011; Corbin and Strauss, 1990). Thus, during the empirical, field-based research in Afghanistan, data collection and analysis were conducted in tandem. This approach was important during the case study research because it was necessary to conduct ongoing analysis in order to determine subsequent sources of evidence (e.g. interviews, focus groups and direct observations) from which to collect data. Theoretical sampling and theoretical saturation aided this process. For instance, theoretical sampling was used to identify concepts and develop categories, and data collection continued until theoretical saturation was reached for each category. Thus, grounded theory procedures directed which data to explore next and where to find the data in order to develop the theoretical scheme during the data collection process.

The coding process was initiated alongside data collection during the case study research. For example, field notes were coded during the empirical, field-based research in Afghanistan. After data collection was completed, the coding process continued in conjunction with the transcription and translation of interviews and focus groups. In addition, abstract interpretations of case study data facilitated the creation of concepts and categories, which represented phenomena that had been broken down into ideas, incidents and events. During the course of the research study, the analytical process was recorded by creating memos and diagrams to properly develop concepts and categories. Finally, constant comparisons were made among phenomena to ensure that a logical theoretical scheme was systematically generated.

The case study research relied upon the three types of coding, which included open coding, axial coding and selective coding. During open coding, concepts and categories were first conceptualised from case study data. Categories were then distinguished from their subcategories during axial coding, which resulted in more precise and complete explanations of phenomena. Later, during the selective coding process, categories were integrated and refined, and a central category was developed. Various techniques including writing the story line, moving from description to conceptualisation and using diagrams and memos facilitated the integration of concepts and the eventual identification of a central category.

Finally, grounded theory was used to generate a theoretical scheme from the raw data in order to test, elaborate and extend existing theory. Although the grounded theory approach allows theory to emerge from the data, Strauss and Corbin (1998) suggest that researchers may begin a research study with an existing theory in mind if their purpose is to elaborate and extend that theory. Further, Miles (1979; pg. 591) indicates that the need to develop grounded theory often exists in tension with the need for clarity and focus during research. Because research studies that presume to commence with no assumptions usually encounter many challenges, a rough framework should be in place at the beginning of field research. He claims, *The risk is not that of 'imposing' a self-blinding framework, but that an incoherent, bulky, irrelevant, meaningless set of observations may be produced, which no one can (or even wants to) make sense of.* The existing theory, or framework, used in the research study was the BoP Impact Assessment Framework. Thus, the framework influenced the initial approach to data collection and theory development, and the aim of the research study is to test, elaborate and extend that theory.

In summary, the overall data analysis process began alongside data collection. Although qualitative data analysis techniques have not reached the level of systematised procedures compared to quantitative data analysis, the grounded theory approach provided broad guidelines for qualitative data analysis. Moreover, the flexible grounded theory procedures, or broad guidelines, were appropriate because rigid procedures are not necessarily desirable in qualitative research. Although some grounded theory procedures do naturally occur before others, the process is iterative rather than entirely linear. Therefore, the general data collection and analysis process that was implemented during the research study is illustrated in the following chart.

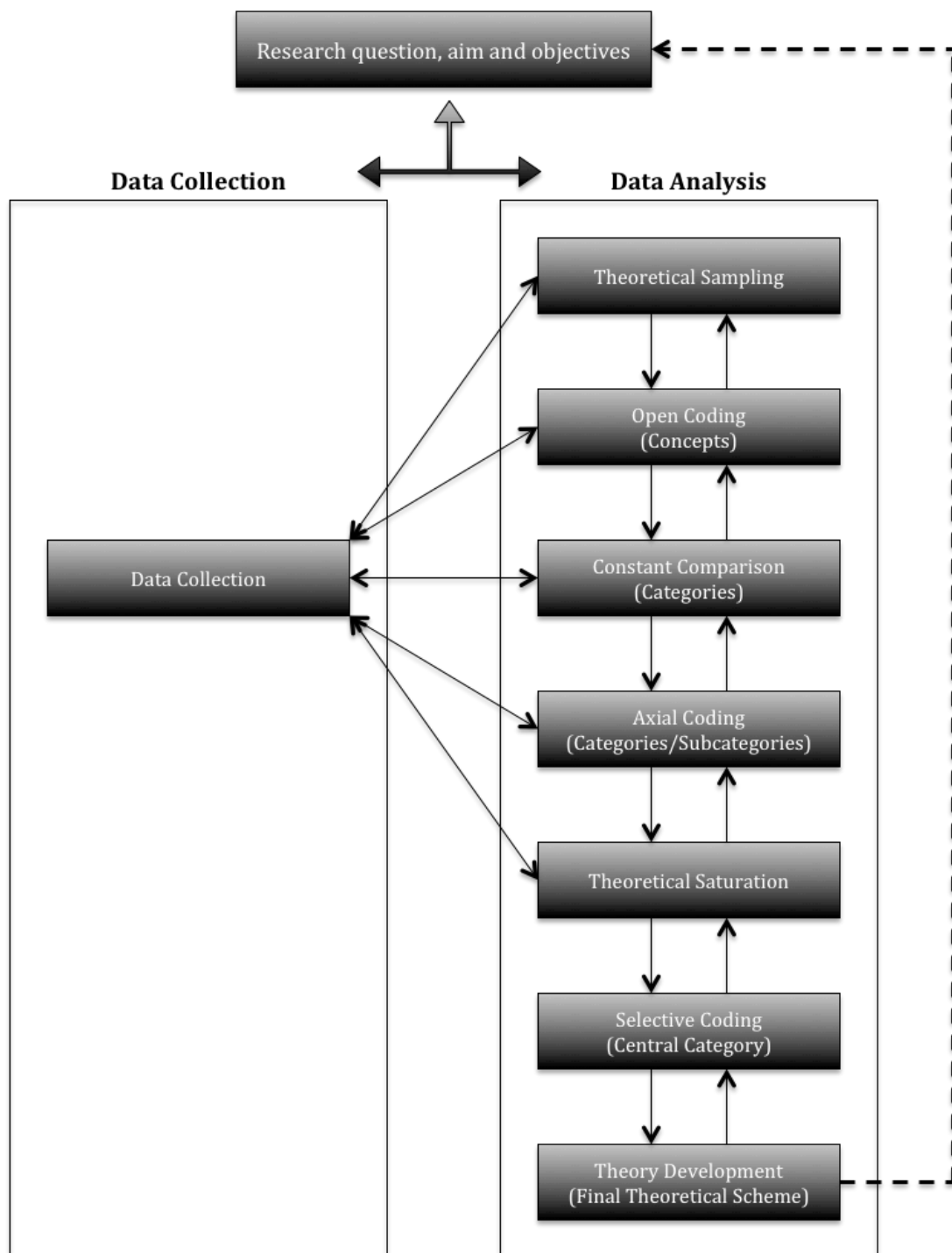


Figure 3.5: Qualitative Data Analysis – The General Grounded Theory Process (SOURCE: Author)

CHAPTER: 4 RESULTS

4.1 OVERVIEW OF RESULTS

As previously discussed, the research study commenced with an existing theory in mind, and the aim of the study is to test, elaborate and extend that theory. Thus, the BoP Impact Assessment Framework not only influenced the general study design, but it also serves as a theoretical template with which to generalise the empirical results (inductive theory) of the case study. In addition, the study follows a qualitative, inductive approach, and grounded theory was used to analyse qualitative data. Therefore, data was collected inductively so that theory emerged out of the raw data, and themes (provided by the existing theory) were used as a general guide for initial data collection instead of a rigid structure used to cram data into pre-existing categories.

For example, the research question did not include the exact categories from the BoP Impact Assessment Framework (“potential changes in economics”, “potential changes in capabilities” and “potential changes in relationships”). Rather, it incorporated more general themes concerning economic and social impact. Thus, the research question included more abstract themes rather than specific categories. This approach to framing the research question was important for three reasons. First, the broad themes were sufficiently abstract to allow categories to naturally arise from the raw data. Second, this approach ensured consistency between the qualitative, inductive approach to data collection and the grounded theory approach to qualitative data analysis. Third, the inductively generated categories were later compared against the actual categories on the BoP Impact Assessment Framework to test, elaborate and extend the existing theory and generalise results.

Further, the research study did not limit data collection to the stakeholders included on the BoP Impact Assessment Framework – buyers, sellers and the community. Rather, the study approached data collection from as broad a range of stakeholders as possible. As previously mentioned, internal stakeholders involved in the study included MSDEV executives, management, residency staff, current medical staff and past medical staff. External stakeholders included community health workers, village elders, health shura members and customers. Again, the point here was to inductively collect data so that theory emerged out of the raw data instead of rigidly forcing data into pre-existing categories. However, the initial themes and stakeholders were defined well enough to provide a rough framework and avoid ending up with ... *an*

incoherent, bulky, irrelevant, meaningless set of observations... which no one can (or even wants to) make sense of (Miles, 1979; pg. 591).

Once the initial themes and stakeholders were identified, actual data collection occurred in three stages. Organisational documents and archival evidence were collected and examined in the first stage of data collection, which included examples such as reports, proposals, training manuals, health clinic activity reports and past surveys. The documentation and archival evidence that was collected in the first stage established an important foundation for the interviews, focus groups and direct observations carried out in the following stage of data collection. In the second stage, empirical data was collected during six weeks of extensive field-based research that took place from May to June 2013 in Afghanistan. This was the most significant and intensive stage of data collection, and the primary sources of data collected in this stage were from interviews, focus groups and direct observations.

During the course of field research, 13 interviews and five focus groups were conducted, which included a total of 55 participants. Limitations during field research included security concerns and language translation. For instance, it was not possible to conduct interviews or focus groups in public areas or homes in Tangi Saidan due to security concerns. As a result, interviews and focus groups were conducted at two separate secure locations (e.g. the community centre in Tangi Saidan and at a Morning Star Development office in Kabul). In addition, the majority of participants did not speak English so translation was necessary during interviews and focus groups. However, all interviews and focus groups were recorded for subsequent transcription and translation.

Thus, the third stage of data collection involved transcription and translation work necessary to prepare data for subsequent analysis. English recordings were simply transcribed, but Dari recordings had to be transcribed and then translated. Field notes were also taken by the researcher and research assistant. Therefore, the research assistant's field notes had to be translated into English. Overall, field research produced approximately 40 hours of audio recordings, which resulted in several hundred hours of transcription and translation work and nearly 1,000 pages of raw data. Due to the deluge of data, it took several months to complete data analysis. As illustrated below throughout the results, triangulation of data occurred as evidence from interviews, focus groups, direct observations, documentation and archival evidence corroborated the same facts or phenomena around converging lines of inquiry.

Data collection and analysis overlapped, and empirical results were developed by theorising about the raw data compiled during data collection and analysed using grounded theory. Therefore, the Results chapter headings and subheadings parallel the categories, subcategories and concepts (theory) that emerged through this process. For example, the category “lower health care costs” represents economic impact while the categories “relationships” and “behaviours” characterise social impact. In addition, the final chapter heading is titled summarising socio-economic impact. This heading represents the central category, socio-economic impact, that emerged during grounded theory analysis. This central category embodies all action and interaction regarding the study and integrates the three main categories to comprehensively capture the entire story.

Thus, the three categories comprise the main chapter headings of the Results chapter, and the final heading represents the central category. The chapter is further organised so that it clearly addresses the research question, aim and objectives. For instance, the research question broadly includes economic and social impact. These themes are similarly reflected within the structure of the chapter headings because they were the general themes provided by the BoP Impact Assessment Framework. The relationship between the themes, categories and central category expounded throughout the chapter is illustrated in the table below.

Research Question, Aim and Objectives (Themes)	Categories (Inductively Generated)	Central Category (Summary of All Impact)
Economic Impact	Lower Health Care Costs	Socio-Economic Impact
Social Impact	Relationships Behaviours	

Table 4.1: Relationship between Themes, Categories and Central Category (SOURCE: Author)

Finally, the focus of the Results chapter is on understanding and improving the nature (e.g. positive/negative) of the economic and social impact of the health clinic in Tangi Saidan. Therefore, the chapter is systematically structured to address the research question, aim and objectives, illustrate the theory development process and ultimately test, elaborate and extend the existing theory.

4.2 LOWER HEALTH CARE COSTS (ECONOMIC IMPACT)

The first category that emerged during grounded theory analysis is “lower health care costs”. This category fits within the first general theme provided by the BoP Impact Assessment Framework – economic impact. To understand how this category emerged during the research study, it is important to consider the particular perspectives, or frames of reference, held by study participants. During conversations with respondents, two reoccurring frames of reference emerged regarding economic impact of the clinic. Participants either stated before the clinic was operational in Tangi Saidan or if there was no clinic in Tangi Saidan in discussions concerning the economic impact of the clinic. This means that respondents considered both what circumstances were like before MSDEV began operating the clinic and what conditions would be like if there was no MSDEV clinic in Tangi Saidan. Therefore, it is important to look through the lens of these perspectives to understand the economic impact of the MSDEV Tangi Saidan health clinic.

In grounded theory analysis, the category “lower health care costs” is too broad of a topic and must be broken down into a sufficient level of detail to actually describe how and why economic impact has occurred. Thus, two subcategories were developed that explain how and why economic impact has been realised – the clinic visit and health education. The clinic visit refers to the cost differential between seeking curative care at the health clinic in Tangi Saidan verses seeking care at a different medical facility and includes concepts such as transportation and lost wages. Health education represents preventative services provided by the clinic in addition to the curative care services and includes concepts such as breastfeeding and maternal mortality. The subcategories and concepts associated with “lower health care costs” are illustrated in the following table.

Category 1 (Economic Impact)	Subcategories	Concepts
Lower Health Care Costs	The Clinic Visit	Transportation Lost Wages Accommodation Gifts (Nazrana)
	Health Education	Breastfeeding Maternal Mortality Family Size

Table 4.2: Category 1 – Subcategories and Concepts (SOURCE: Author)

4.2.1 The Clinic Visit

The first subcategory is the clinic visit, which is comprised of several concepts including transportation, lost wages, accommodation and gifts (nazrana). Respondents repeatedly emphasised the additional costs that would be incurred if there was no health clinic in Tangi Saidan. The majority of Afghans live in rural parts of the country so it is not uncommon for patients to travel (sometimes long distances) when seeking medical care. Likewise, the MSDEV Tangi Saidan health clinic services rural villages. Thus, the fact that MSDEV provides a range of health services at the clinic in Tangi Saidan significantly lowers health care costs for people living in the surrounding villages. A table of the various categories of respondents can be found in Appendix 2, and the relative contribution by respondent category for each concept regarding the clinic visit is illustrated in the following table.

The Clinic Visit				
	Transportation	Lost Wages	Accommodation	Gifts (Nazrana)
Categories of Respondents	* Past Medical Staff			
	* Medical Staff	* Medical Staff	Medical Staff	* Medical Staff
	Health Shura	Health Shura	Health Shura	Health Shura
	CHW	Customers	Customers	CHW
	Customers			Customers
	* Indicates if a key informant was involved			

Table 4.3: Relative Contribution by Respondent Category – The Clinic Visit (SOURCE: Author)

In general, respondents suggested that direct medical expenses (e.g. office visit, medicine) would be about the same whether in Tangi Saidan or another village or city. However, they cited numerous expenses that would be incurred (beyond direct medical expenses) if there was no clinic in Tangi Saidan such as transportation and accommodation costs. Therefore, to accurately quantify the direct economic impact of the health clinic, it was necessary to uncover all of the various expenses (and other potential economic impacts) that would be incurred by seeking care at a medical facility other than the Tangi Saidan health clinic. Each of the following concepts below expound on how the clinic visit in Tangi Saidan lowers health care costs for patients served by MSDEV.

4.2.1.1 Transportation

The geography of Afghanistan can be described as urban, rural and remote. Urban areas include the cities such as Kabul, Herat, Kandahar or Jalalabad. Rural parts

of the country comprise villages outside of the cities that can normally be reached by motorised transportation. However, due to the mountainous terrain of the country, there are also remote areas that are mostly accessible by walking or by animal. These areas may or may not be accessible by motorised vehicles and may only be accessible part of the year due to heavy snowfall. Thus, geography is important to note because it impacts both transportation and health care provision in Afghanistan (Johns et al., 2013; Morikawa et al., 2011; Trani et al., 2010).

For instance, approximately 80% of the population lives in rural (including remote) areas, and it is the rural population that represents the majority of the poor in Afghanistan (Islamic Republic of Afghanistan, 2013). The 2006 AHS revealed that approximately 75% of Afghans living in rural (including remote) areas rely on walking to travel to the nearest health facility. Only about 12% utilise a public bus, and 11.5% have access to a private automobile for travel to the nearest health facility (Afghanistan Ministry of Public Health, 2006). The 2008 APSHS reported that roughly 42% of Afghans living in rural (including remote) areas have no form of transportation other than walking, and that the second most common mode of transportation other than travelling by foot was by animal (33%). Only about 14% have access to a car, van or truck (Alsi et al., 2009). As a result, it is common for transportation to be both costly and a barrier to health care provision in Afghanistan.

Consequently, transportation was one of the greatest economic impacts cited by respondents in the research study. The MSDEV health clinic is located in Tangi Saidan, which is a rural (not remote) village south of Kabul, and the clinic serves a total of 39 smaller villages that surround Tangi Saidan. The majority of patients walk to the clinic, and it takes approximately 30 minutes on average to walk from the surrounding villages. Walking from the villages closest to Tangi Saidan may take about 15 minutes whereas walking from the furthest villages may take more than an hour. However, if there was no clinic in Tangi Saidan, patients would be forced to travel to Kabul to seek medical attention. Respondents consider Kabul too far and dangerous to walk, and there is no public bus system available from Tangi Saidan. Therefore, in the absence of the MSDEV clinic, patients would have to rent a taxi to travel to Kabul for medical treatment.

During discussions with respondents, transportation was often the first, and most common, economic impact cited. As stated above, the common consensus was that patients would travel to Kabul if there was no Tangi Saidan clinic. For example, one medical staff member stated, *If there was not a clinic in Tangi Saidan, then people had*

to take the patient to Kabul, for most of the time they had to stay over night in Kabul and pay a lot for accommodation, food and car rent. So, totally it cost them a lot. Now there is a clinic in Tangi Saidan. Patients can come to the clinic very easily and don't have spend money. Therefore, people are happy about this fact.

Although no respondents suggested they would take a public bus to Kabul, there seemed to be some inconsistencies concerning whether public buses were available in Tangi Saidan. Most respondents simply stated that there are no buses available in the village. This was consistent with direct observations, in which no buses entered or exited Tangi Saidan. The observations were fairly straightforward because there is only one road into the village from Kabul, and the road passes right in front of the clinic. On the other hand, a few respondents did mention that public buses are sometimes available. This initially seemed inconsistent with what other respondents had stated about the availability of public buses in Tangi Saidan. It was later clarified that there is no direct bus service into the village of Tangi Saidan, but there is a bus stop between Tangi Saidan and Kabul.

If a person travelled to the bus stop, he or she would still have to walk or take a taxi to the bus stop. The patient would also have to walk or take a taxi to the health facility once in the city of Kabul because the public buses do not provide direct service to Kabul medical facilities. For example, a member of the health shura explained, *Public transportation is very cheap but it doesn't meet the need of a patient getting to any clinic. When patient use public transportation he is to take a taxi from the bus stop to the clinic too, that totally it cost him 300 Afs for a round trip.* Respondents further stated that public transportation is inconsistent, that it could be dangerous (some gave stories of robberies) and that they do not prefer to send their wives and daughters to Kabul on public transportation. Thus, the consensus was that taxis are the normal means of transportation from Tangi Saidan to Kabul.

Transportation is an important economic impact because travelling to Kabul by taxi is fairly expensive for Afghans living in Tangi Saidan and the surrounding villages. Respondents stated that the average round trip taxi fare is between 600-1,200 Afs depending upon the location, time of day (or night), availability of taxis, time of year and occasional security problems. For example, a key informant described, *It depend to the village they live. If closer, rent for taxi is low, but if far away from the main road, rent for taxi higher.* Taxis also tend to be more expensive at night, during the winter when there is heavy snowfall and when there are heightened security concerns in the area.

If a person from a distant village needs a taxi at night in an emergency, respondents suggested the fare could cost as much as 2,000 Afs. For instance, a CHW indicated, *During the night the cost may be so high... as it is so difficult to find a car and hire it to go to Kabul*. Although transportation costs can be very high in certain severe situations, this is not common. Therefore, the research study revealed that the conservative estimate for round-trip taxi fare to health facilities in Kabul would be roughly 900 Afs. This is a relatively significant amount given the average daily wages of the people living in the villages surrounding Tangi Saidan, which is discussed in the following section. These findings were consistent with the literature concerning the economic relationship between transportation and health care. In fact, reports stress that the high cost of transportation is one of the primary reasons Afghans often do not seek medical attention (Afghanistan Ministry of Public Health, 2006; Singh et al., 2012).

4.2.1.2 Lost Wages

A second significant economic impact cited by respondents was lost wages associated with seeking medical attention in Kabul. If there was not a health clinic in Tangi Saidan, all respondents stated they would seek care in Kabul. As discussed above, transportation is one factor that impacts the total time required when seeking medical attention. Most patients walk to the Tangi Saidan clinic, which takes about 30 minutes on average. In contrast, patients must call and wait for an available taxi in order to travel to Kabul, and actual transport may take one to two hours. Thus, it may require a total of two to three hours of travel time to reach a health facility in Kabul.

An additional factor is the time it takes for a patient to be seen by the doctor at a health facility. It is common across Afghanistan for patients to crowd clinics very early in the morning because patient scheduling is not a standard practise. This is typical in Tangi Saidan and Kabul. Mass crowding of clinics early in the morning places patients travelling long distances under an additional burden. Thus, respondents complained that it would ordinarily take at least one full day for a patient to see a doctor when travelling from villages surrounding Tangi Saidan to a health facility in Kabul. For example, when asked how long it would take to receive medical attention in Kabul, one medical staff member exclaimed, *At least it take him one day because of heavy traffic in Kabul and clinics are busy*.

If patients had to travel to Kabul to seek medical care, they would likely arrive at the health facility around mid to late morning at the earliest. However, depending on availability of taxis and congested traffic, it could be early afternoon before a patient

arrives at a Kabul facility. By this time, lines are very long at health facilities, and patients often must wait until the next day to receive medical attention. One member of the health shura described the difficulties seeking medical attention in Kabul, *First, transportation problems cause a patient to be late at the clinics in Kabul. Second, clinics in Kabul as usual are so crowded so a patient needs to wait in a long line for doctor.* In this case, respondents suggested that patients would have to spend the night in Kabul to see a doctor the following day if they are not able to make it to the medical facility early in the morning. A medical staff member explained, *If a patient leave home early in the morning, he can come back home till night. But if he go to Kabul in afternoon, he can't come back and has to stay in Kabul overnight.*

Conversely, the situation in Tangi Saidan is very different. Several respondents said they could see a doctor in as little as 15-20 minutes in Tangi Saidan, but most stated that it typically takes about one to two hours. A key informant described the difference between seeking medical care in Tangi Saidan and Kabul, *The distance between people and Tangi Saidan clinic is like the distance between hand and sleeve. Normally, when a patient come to Tangi Saidan clinic he doesn't have to wait for so long time that people wait in line at clinics in Kabul. The longest time that a patient may wait in line at Tangi Saidan clinic is not longer than 2-3 hours but in Kabul normally people wait for 5-6 hours. Also, going to Kabul need a bigger preparation like having another person to go and take a taxi from the road or other far places, that it takes time also.*

Numerous other respondents compared the differences between seeking medical care at the Tangi Saidan clinic verses medical facilities in Kabul. For example, one customer stated, *When we go to Tangi Saidan it takes between 1-2 hours, but if we go to Kabul, it takes a day.* One of the medical staff members added, *It takes a patient one day to go to Kabul and be back because of heavy traffic and clinics being so crowded. But in Tangi Saidan clinic it take a patient only one hour to be examined and dismiss from the clinic.* Thus, availability of medical care in Tangi Saidan represents an important economic impact for villagers due to lost wages from missing work.

Respondents concurred that villagers do not miss work when visiting the health clinic in Tangi Saidan. For example, when the health shura was asked how much work a person would miss to visit the Tangi Saidan clinic, one member indicated, *He [the patient] doesn't miss any even work hours because seeing a doctor only take 15-20 minutes, so it is not a big deal.* However, when asked how much work a person would miss to visit a doctor in Kabul, another member added, *Of course, he [the patient] will*

miss one day of his work. Thus, the work situation would be different if community members had to travel to Kabul for medical treatment. One customer explained the difference between missing work to visit the clinic in Tangi Saidan versus health facilities in Kabul, *If we go to Kabul, he [the patient] misses one day [of work], but in Tangi Saidan he doesn't miss any day.*

Therefore, economic impact can be defined by daily wages saved through the availability of the health clinic in Tangi Saidan. For instance, most men work as day labourers in agriculture, and a smaller portion of men work cutting stone in the surrounding mountains. The majority of women do not work, but some women are able to work as day labourers in agriculture. Most respondents suggested the average wages are roughly 400 Afs per day. Women tend to get paid less and men who work as stone cutters tend to earn a bit more. In addition, agricultural jobs are only available nine months out of the year so annualised average incomes would likely be slightly less than 400 Afs per day. In addition, to better understand economic impact due to lost wages, it is important to take several factors into consideration.

First, MSDEV activity reports show that the majority of patients visiting the Tangi Saidan clinic are women and children. For instance, when aggregating clinic visits for 2012 and 2013, approximately 80% of all new visits were by women and children under the age of five. This means that male patients over the age of five comprised only 20% of total new visits during 2012 and 2013. Second, it is a common cultural requirement for women to be accompanied by an escort, or *Maharam*, in order to leave their home residence. This individual must be the woman's husband or a male relative. Women therefore need Maharam in order to seek medical treatment at a health facility. In fact, studies reveal that this cultural practise is a common barrier to women receiving proper health care in Afghanistan (Reilley et al., 2004; Singh et al., 2012).

Third, the MSDEV activity reports disclose that the average number of new visits to the health clinic in Tangi Saidan may rise during peak earning months in some years. For the region surrounding Kabul, the primary agricultural earning months are normally March-November (FEWS NET, 2011). In 2012, the average monthly new visits to the Tangi Saidan health clinic were approximately 30% higher during these peak working months (compared to average visits for January, February and December). The average new visits were only 5% higher, however, during the same time period in 2013. Thus, the earnings of many villagers (mostly working in the agricultural sector) could be impacted significantly in some years if there was no clinic in Tangi Saidan. In addition, this uncertainty reduces overall income stability.

Considering the abovementioned factors, the health clinic in Tangi Saidan has had a significant positive economic impact regarding lost wages from sick days. As mentioned above, the primary clinic patients are women and children, and women need Maharam to visit medical facilities. Therefore, although women would not typically lose wages to visit a clinic in Kabul (since they do not normally work outside the home), the male Maharam would face lost wages due to missing work. Further, the fact that the average number of clinic visits may rise during peak working months (in some years) for men would exacerbate the lost wages of male Maharam travelling with women and children to seek medical attention in Kabul.

However, in contrast to the literature and the situation across most of Afghanistan, the research study discovered a very interesting phenomenon regarding the Tangi Saidan health clinic. In fact, the discovery was one very significant finding that occurred during the course of the study. It found that while a male (relative) escort would be necessary for women (including women taking children to the clinic) to seek medical attention in Kabul, Maharam is not required for women to visit the Tangi Saidan clinic. For example, a medical staff member explained that women (with their children) are able to travel to the Tangi Saidan clinic without Maharam, *Yes, because Tangi Saidan clinic is close to villages, whenever someone in a family get sick she can come to the clinic by herself, and man of the family normally doesn't have to miss any work days. So, he is happy too.*

The phenomenon concerning Maharam is discussed in greater detail concerning social impact of the MSDEV health clinic. Nevertheless, it is important to note here because it has substantial economic implications. If there was no health clinic in Tangi Saidan, male relatives would be required to escort female patients to Kabul. Because the vast majority of patients are women and children, men would miss many more days of work per year if the Tangi Saidan clinic did not exist. However, the Tangi Saidan clinic has had a significant positive economic impact on wages because men do not miss work to visit the clinic, and women and children can travel safely to the clinic without Maharam.

4.2.1.3 Accommodation

A third economic impact identified by respondents in the research study was accommodation, which is also associated with travelling to Kabul to seek medical treatment. Accommodation includes both food and lodging. As discussed previously, the Tangi Saidan clinic lies within walking distance of the surrounding villages, and

most patients are able to see a doctor within approximately one to two hours. Therefore, food and lodging are not necessary for clinic visits to Tangi Saidan. On the other hand, patients (and those accompanying them) will incur food expenses when travelling to Kabul to seek treatment because it will take at least one full day in Kabul to receive medical attention. In addition, lodging may be necessary if patients must spend the night in Kabul to see a doctor the following day.

Therefore, not only would patients incur transportation expenses and face lost wages from missing work, but they would also have to pay for food and possibly lodging if required to spend the night in Kabul. If a woman visited a Kabul clinic and had to spend the night, accommodation expenses would be incurred for her and each companion accompanying her (Maharam). The 2006 AHS correlates travel time with accommodation expenses. The survey reports, *If patients from poorer households have to spend more time traveling to a health facility, they are more likely to pay for food or lodging as part of their treatment seeking*. According to the survey, approximately 28% of respondents paid for food and lodging when travelling between two to three hours to a medical facility, and 23% paid when travelling less than two hours to a facility (Afghanistan Ministry of Public Health, 2006; pg. 69).

The survey is relatively comparable to what respondents in the current research study reported concerning travel to Kabul for medical treatment. However, the inability to see a doctor during the first day upon arrival into Kabul is the main determinant regarding what and how much patients (including Maharam) would spend on accommodation expenses. Because women (the primary customers of the Tangi Saidan clinic) require Maharam, accommodation costs can add up for the poor if required to travel to Kabul to visit medical facilities. In addition, most respondents claimed that men would usually travel with at least one other person if seeking medical treatment in Kabul (although this is not required).

The responses varied when determining the costs of food and lodging, but the average was between 350-600 Afs per person per day for food and roughly 300-500 Afs total for a single night of lodging. Due to the cultural norms discussed above, average accommodation costs are estimated for two people. For example, when asked how much food and lodging would cost per person per day if seeking medical treatment in Kabul, one customer stated, *The lunch would cost 150 Afs, Dinner 150 Afs, Breakfast 50 Afs and the room rent 300 Afs*. When asked the same question, a member of the health shura estimated, *The expenses are: room rent is 500 Afs, lunch 200 Afs, Dinner 200 Afs and breakfast 100 Afs*.

It is also important to note that some residents in the villages served by the Tangi Saidan health clinic may have relatives in Kabul. In that case, the relatives would typically provide lodging (and possibly some food) for the patient (and Maharam). For example, one member of the health shura commented, *Most of the people spend night in their relatives' houses*. Therefore, if a female patient (with Maharam) was able to travel to Kabul and return in a single day, the total accommodation expenses would likely be about 300-600 Afs depending on the number and price of meals eaten during travel (no lodging necessary). Accommodation expenses, however, could range from 600-2,000 Afs if spending the night in Kabul. In this event, the total accommodation cost is contingent on the necessity and price of lodging as well as the number and price of meals purchased. On the other hand, patients do not incur any accommodation expenses when receiving treatment at the Tangi Saidan health clinic, which results in a significant cost saving compared to seeking medical attention in Kabul.

4.2.1.4 Gifts (Nazrana)

A final economic impact discussed by respondents in the study was nazrana. Nazrana is a term that represents a cultural practise in Afghanistan of giving gifts, which often equate to small bribes or informal payments in professional settings. The standard Dari word for a bribe is *reshwat*, but most Afghans use the slang word *shereny*, which is something that tastes sweet like candies or a dessert. Whereas *reshwat* and *shereny* are more clearly understood as bribes, *nazrana* is often viewed as more of a gift than a bribe. For example, when asked about whether *nazrana* was a gift or bribe, an informant said, *It is 50-50*. In other words, this is a grey area in which *nazrana* can be understood as a gift, bribe or a little of both.

Further, respondents were uncomfortable when asked if they had paid or accepted bribes. On the other hand, they were very willing to openly discuss the exchange of gifts translated as *nazrana*. For example, when asked whether it is common for doctors to take bribes, one key informant replied, *No doctors change their reputation for a big money. They put on the white coat that is the symbols of honour and honesty*. However, when the informant was subsequently asked whether doctors would accept a financial gift (*nazrana*) from a patient, he admitted, *Yes, if it is a gift though*. Thus, the cultural practise of making informal payments (whether bribe or gift) is not as clear-cut in Afghanistan compared to other cultural contexts.

Respondents held fairly similar perspectives concerning the giving of gifts to staff at medical facilities with only a few minor nuances. Three general views emerged

concerning nazrana during interviews and focus groups with respondents. The first perspective was that nazrana is not expected at the Tangi Saidan health clinic. There were two variations of this first perspective. The first variation of this perspective is that staff members would not expect, or even accept gifts at the Tangi Saidan clinic. For instance, one medical staff member argued, *No, neither patients give gift to doctors nor doctors accept the gift from patients. If some accept the gift it means that he takes of the cloth from a dead body.* A second staff member agreed that, *At Tangi Saidan clinic, neither patients give gift to health staff, nor the health staff ask them for gift.* This variation of the first perspective was only communicated by a minority of the medical staff members during interviews.

The second variation, however, was more widely held among the majority of stakeholders. Consequently, these respondents emphasised that although medical staff members in Tangi Saidan do not expect nazrana, they would accept a gift if offered by the patient. Also, any gift given to the medical staff would normally be a food product instead of money. For instance, one medical staff member described that, *Doctors never expect the patients to give them any gift, but if sometime the patient himself wants to give gift to doctor, surely doctor will accept that.*

Health shura members, whose responsibility is to oversee the Tangi Saidan health clinic, also expressed the second variation of this perspective. One member of the health shura stated, *No, neither doctor nor other health staff expect any patient to give them any gift in both places, in Kabul and Tangi Saidan. But if a patient gives some food or fruit by his/her wish, they will accept it.* In addition, one of the customers concurred that, *Both in here and Kabul the doctors don't ask for nazrana or gifts, but it depends, if the patient wants to give them so they will receive it.*

Another staff member admitted receiving gifts from patients, *At Tangi Saidan they bring me milk, yogurt and fruits as gift but not money.* One of the CHWs also acknowledged, *Sometimes our villagers give us some fruit and some dairy as a gift when they born a baby.* Furthermore, a managerial staff member reported, *Yes, sometime patient give gift to some health staff in Tangi Saidan clinic. Yesterday, I saw the [staff member] with a bag full of something, and I knew there were some gift in that bag.*

A second common perspective was that gifts are sometimes expected by staff in Kabul medical facilities depending upon the specific medical facility and position of the staff member. Respondents noted that several different staff members in Kabul medical facilities may demand nazrana including the doorman, nurses, doctors and even the

person dispensing tickets for the queue. For instance, one of the Tangi Saidan clinic staff members criticised this practise, ... *in Kabul if you don't give something to the doorkeeper of the clinic or hospital, he doesn't allow you even to enter the hospital.* A CHW implied that overcrowded medical facilities in Kabul often contribute to the problem, *It depends if the doctors are busy, so you need to give some money to the person who gives tickets for patients to give you a good number for visiting doctor.* A customer also complained about the practise of bribing the person distributing tickets, ... *those who are working with doctors as a ticket distributor, the people give them money in order to get a good ticket number to visit the doctors sooner than others.*

When asked about the total cost of nazrana given to the various staff members, respondents explained that it depends on various factors such as the number of staff members demanding gifts and the wealth status of the patient. As a result, although most respondents suggested that the average cost of nazrana for a single office visit might be approximately 200-300 Afs, some claimed the total cost could be much higher. For example, one of the managerial staff members described, ... *it depend on the financial condition of the patient, and it depend on how can both sides make deal with each other. From 100-500 Afs [is common].* He continued, *I can't say the average because there is not one person who asks for money, there are many different staff like cleaner, watchman and nurse. Each of them ask for different amount of money that totally it would cost the patient 600-700 Afs.*

The third common perspective shared among respondents was that the medical staff in Kabul birthing hospitals customarily expects (and may even demand) nazrana. This is important to note because doctors and midwives at the Tangi Saidan health clinic perform deliveries for most women living in the surrounding villages. In addition, whereas nazrana is occasionally expected in many medical facilities in Kabul, almost all respondents cited that nazrana is regularly expected in birthing hospitals. As is the case in other medical facilities, gifts may be given to a variety of staff members, which can include doctors, nurses and even doormen. One CHW said, *In Kabul in delivery hospital, the nurses ask for gifts and nazrana.* A customer added, *In Kabul the doctors don't ask for gifts except [in] delivery hospitals [and] the doormen and nurses are asking for.*

Most respondents concurred that the average gift at a birthing hospital would be at least 500 Afs, but it could be much higher. For example, one CHW stated, *Yes, this [nazrana] is usual in Kabul, especially in delivery hospitals. If you have a baby, you should pay an average of 500 Afs.* A customer similarly agreed that, *In Tangi Saidan the*

doctors don't ask for, but in Kabul in the delivery hospitals the doormen and nurses are asking for some money between 500-1,000 Afs. As discussed above, the amount of nazrana given can vary significantly depending on the financial status of the patient and his or her family. For instance, one of the members on the health shura explained that, ... in delivery hospital when a baby boy is born, normally the father of the baby give some gift to anybody he wants by his wish. The amount of the money depends on generosity of the father of the baby that is between 100-5,000 Afs.

There is considerable documentation from the literature that corroborates the common practise of making informal payments (whether considered bribes or gifts) to staff in medical facilities. Many reports reveal that corruption is endemic throughout Afghanistan, and that bribery is typical in the delivery of health care. For example, among Afghans who had paid bribes, between 15-20% admitted paying doctors, nurses and paramedics in 2012. The average recorded amount of bribes paid to these medical professionals was approximately \$100 (Paterson, 2006; UNODC, 2010, 2012).

Singh et al. (2012) express that the culture of staff demanding money as nazrana often discourages families from opting for institutional delivery. The authors also document that staff demanded informal payments for items (most of which are normally provided by the medical facility) such as soap, shampoo, handkerchiefs and even sweets. Cockcroft et al. (2011) also found that informal payments may be made to a range of diverse staff members from the doorman and ticket distributor to nurses and doctors. Some respondents said they only paid doctors and caretakers while others complained that they paid all the personnel in the facility. This study found that the informal payments could potentially place a large financial burden on the patient's family. Families felt that if they did not pay, they would not receive treatment. Subsequently, when families do not have the money available, they often have to sell assets (e.g. livestock) or take loans.

In summary, cost savings associated with nazrana represents a fourth economic impact of the Tangi Saidan health clinic. Although gifts are sometimes given at the Tangi Saidan clinic, they are infrequent and are never expected. Moreover, respondents reported that any gift given in Tangi Saidan would not be monetary, but rather the gift would be a food product, which is often grown or produced by the patient. The literature, however, documents that paying gifts or bribes is common in the health care sector across Afghanistan, and that the total amount paid may be (in some cases) large enough to place a financial burden on the family. Further, most of the respondents in the current research study indicated that nazrana is often expected in most Kabul medical

facilities and may even be demanded (e.g. in delivery hospitals). As a result, community members may save several hundred Afs per clinic visit due to the existence of the Tangi Saidan health clinic.

4.2.1.5 Summary

As described above, there were four primary economic impacts associated with the first subcategory – the clinic visit. These economic impacts have collectively resulted in lower health care costs for the people served by the Tangi Saidan health clinic. The four concepts that comprise the economic impact from the clinic visit are transportation, lost wages, accommodation and gifts (nazrana). From the combined concepts, it is possible to estimate a conservative average cost savings range for a single clinic visit. For example, round trip transportation would typically cost between 600-1,200 Afs for a single clinic visit to Kabul. Lost wages from missing work required to travel to medical facilities in Kabul would likely range between 400-800 Afs because it takes an average of one to two days to seek care in Kabul and wages are approximately 400 Afs in the region surrounding Tangi Saidan.

Accommodation costs include food and lodging and would range widely depending on the number of days required to receive medical attention in Kabul and the number of people accompanying the patient. Thus, the average cost for accommodation may range from 150-1,000 Afs. The average amount related to giving gifts (nazrana) also has a fairly wide range depending upon the medical facility, number of staff demanding nazrana, reason for seeking medical care (e.g. delivery) and wealth status of the patient. Because most families served by the health clinic in Tangi Saidan are poor and the clinic staff performs deliveries for women living in the surrounding villages, the average cost savings would likely range between 100-500 Afs. In total, the estimated average cost savings for a single clinic visit is between 1,250-3,500 Afs. Assuming a standard wage of 400 Afs, the cost savings attributed to an average single clinic visit might equal approximately three days of wages.

It is important to note that the economic impact associated with most clinic visits would likely fall closer to the lower end of the range. This is because events like giving birth or hiring a taxi at night in an emergency occur much less frequently compared to the average clinic visit associated with respiratory infections, diarrhea, stomach problems or other common illnesses. Nonetheless, average cost savings attributed to the clinic visit are significant for families served by the Tangi Saidan clinic. Thus, if the health clinic did not exist, health care costs could be a significant financial burden on

families, and as a result, they may have to sell assets (e.g. livestock) or take loans to pay medical costs. Respondents suggested that borrowing from relatives is common when families need extra money. For example, a CHW explained, *If a person doesn't have enough money, then he is going to borrow from one of his close relatives.*

Finally, although the clinic visit has substantially impacted health care costs for families living in the villages surrounding the health clinic, these curative care services do not represent the only economic impact the health clinic has had on the surrounding community. The health clinic also provides preventative services in the form of health education, which is focused on changing attitudes and behaviours of families served by the Tangi Saidan health clinic. As certain attitudes and behaviours have changed, families have experienced positive changes in their economics. Thus, the second subcategory that illustrates the economic impact of the clinic is health education.

4.2.2 Health Education

The health education services provided by MSDEV have impacted the surrounding villages both socially and economically. Various topics covered within MSDEV educational services in Tangi Saidan include family planning, maternal health, general hygiene and first aid. Thus, much of the impact from health education has been socially oriented and is discussed in more detail regarding social impact of the health clinic. However, respondents described three economic impacts resulting from MSDEV's health education programme – breastfeeding, maternal mortality and family size. Although these areas represent social phenomena, each also delivers a potentially significant economic impact upon families served by the Tangi Saidan health clinic. A table of the various categories of respondents can be found in Appendix 2, and the relative contribution by respondent category for each concept regarding health education is highlighted in the following table.

	Health Education		
	Breastfeeding	Maternal Mortality	Family Size
Categories of Respondents	Medical Staff	* Medical Staff	* Medical Staff
	CHW	Health Shura	Managerial Staff
	Customers	CHW	Health Shura
			Customers
	* Indicates if a key informant was involved		

Table 4.4: Relative Contribution by Respondent Category – Health Education (SOURCE: Author)

Unlike the clinic visit above, the economic impact from health education is not as easily or clearly quantified (e.g. round trip transportation expense 600 Afs). Nonetheless, health education provided by MSDEV has had an economic impact on the community. For example, whereas the clinic visit represents certain cost saving for a single event, cost savings associated with health education have been realised as a result of changed attitudes and behaviours. Thus, the economic impact is related to behavioural change rather than a distinct event, and the economic impact of health education may possibly be further reaching (albeit less tangible) than the clinic visit.

4.2.2.1 Breastfeeding

According to Waldman and Hanif (2002), little data was available before 2002 concerning certain household health practises such as breastfeeding. However, years later, respondents in the 2006 AHS reported that 83% of children are exclusively breastfed for the first five months. However, more than 60% of respondents did not feed their infant breast milk immediately after birth or did not remember. In particular, there is some evidence that colostrum (critical for newborns within the first few days of birth) is considered unclean in Afghanistan, so it may be discarded. In addition, evidence from the 2006 AHS suggests that infants in Afghanistan may frequently be given tea or maska (butter) soon after birth. Because some mothers might not consider these items as supplemental foods, they may not have reported giving them to infants on the survey. Thus, the high percentage of women reporting that they exclusively breastfed their children in the 2006 AHS may be overestimated (Afghanistan Ministry of Public Health, 2006).

The 2007/8 Afghanistan National Risk and Vulnerability Assessment reported an exclusive breastfeeding rate of 78% for the first six months. However, the rate drops to 35% when information about additional liquids in the first few days is included. For instance, 55% of mothers reported giving their newborn liquids other than breast milk within the first three days of birth. These additional liquids included sugar water, glucose, herb water or tea, melted butter and powdered milk. Therefore, the breastfeeding indicators should be interpreted with caution because they vary considerably depending on whether or not feeding patterns during the first three days are included. In addition, mothers were not directly asked in surveys what liquids the child was given in the past 24 hours (De Bruijn, 2009).

Interestingly, the current research study encountered some similar findings. However, as mentioned above, no data is available before 2002 concerning

breastfeeding, and no surveys have been administered in the villages surrounding Tangi Saidan. Therefore, evidence cannot be officially quantified until larger-scale surveys are conducted. Nevertheless, respondents consistently communicated that women often did not breastfeed before the clinic was established. In fact, the primary Tangi Saidan clinic doctor suggested that possibly as few as 50% of women in the Tangi Saidan area breastfed before MSDEV began to provide health education services. He had not conducted a survey, but the doctor had practised at the health clinic since its inception. Therefore, the 50% was his estimate since he had first-hand experienced of the health practises before the clinic was established.

The doctor further explained that although many women did practise breastfeeding, other women fed their infants formula or milk from cows or goats. For instance, he stated, *Before our family planning the family didn't do breastfeeding a lot, and most of mothers when refer to us in the clinic asked me to advise them [about which] formula [to purchase]. But since beginning of this programme we did a wider public awareness regarding breastfeeding, and now the people know the importance of breastfeeding.* The doctor continued, *In the past time, mothers mostly use from animal milk like cow, goat and sheep and a small number used from powder milk, but now a large number of mothers do breastfeeding.* A female customer acknowledged that these practises were common, *In the previous time, the mothers mostly feed their children by formulas and animal's milk, but nowadays a large number of mothers do breastfeeding.*

Respondents cited various reasons concerning why women failed to breastfeed before the clinic was established. Responses often reflected a general lack of knowledge or misinformation regarding the value or benefits of breastfeeding. In addition, many women were simply unable to breastfeed or were not aware of how to properly feed infants. For example, a medical staff member explained, *In the past time the people didn't know about the value of breastfeeding and this was that most of the children were very weak and faced with malnutrition, [and] they didn't know how much water should be mixed with the formula.* One of the CHWs added, *Very few mothers did breastfeeding. Since starting of this project the clinic staff impart the value of breastfeeding to mothers, and now most of mothers do breastfeeding and know the importance of breastfeeding.*

One of the female customers admitted, *In the previous time, the women thought that if they breastfeed their new born babies it would have a bad effect on their [the baby] body.* In fact, CHWs stated (and the reports noted above) that women often did not understand the importance of breastfeeding their babies colostrum directly after

birth. Another customer claimed, *In the previous time, most of the mothers feed their new born babies by goat, cow and sheep's milk, but nowadays the people have realised the benefit of breastfeeding and do it now.* Further, one of the medical staff members (also a midwife) explained that some women thought animal milk was superior to the mother's milk, *Also they didn't know if breastfeeding is very beneficial to them... Most of them thought that animal milk is a stronger food for kids and in future their kids may be very strong and with physical power.*

A CHW described that some women were unable to produce enough milk to breastfeed due to the lack of knowledge concerning nutrition, *In the previous time, the mother didn't know how to feed themselves and didn't know which food have the most vitamin and other useful minerals, and this was the main reason that they couldn't breastfeed well. But nowadays the mothers know that how to feed themselves and how to prepare food rich of vitamin and minerals for themselves, and now they avoid using spoiled food.* Although respondents suggested that breastfeeding practises were inadequate before the clinic existed, they concurred that the health education significantly impacted the breastfeeding practises of women served by the clinic. For instance, one medical staff member indicated, *After this clinic got established and became active, mothers received trainings regarding how important is breastfeeding.*

In addition, one of the CHWs added, *Yes, the family planning programme had a good impact on women especially in breastfeeding. Under this programme, the clinic staff preached the value of breastfeeding to mothers.* The primary clinic doctor claimed that he believes approximately 80-90% of women now practise breastfeeding (up from the estimated 50% he stated earlier) as a result of the health education provided by the clinic. He explained that, *We give some information regarding the advantages of breastfeeding to mothers, and from the other hand we advise mothers on bad effect of formula on their sons. So, through educating people we succeeded to bring such a big increase.* Another medical staff member agreed with the estimates, *In the past about 50-60% percent of mother breastfed... Now 90% of mothers breastfeed their child.*

As discussed above, respondents suggested that many women frequently relied upon formula as well as the milk from cows, goats and sheep to feed infants. Most women, however, have now switched to breastfeeding. Consequently, families have realised cost savings in two areas. First, respondents claimed that breastfeeding is cheaper than the other alternatives. Cow, goat or sheep milk is available and relatively inexpensive in the villages (and may even be produced by animals owned by the family) so represents a nominal economic impact. Formula, on the other hand, is fairly

expensive. Respondents suggested that formula typically costs about 200 Afs per week and roughly 10,000 Afs per year if used exclusively. Thus, respondents emphasised that whether families relied upon formula exclusively or as a supplement, the switch to breastfeeding represents an important economic impact.

Second, there are health ramifications for the child from breastfeeding, which may lead to a possible economic impact. One of the Tangi Saidan doctors explained, *According to the medical term when the baby you know how the breastfeeding, they are less facing with the disease. Their immune system becoming strong because mother's milk is stronger than all formulas the chemist or pharmacies are making. Those kids are less facing to the disease, their immune system is strong [and] they stay healthy.* As a result, the doctor continued, *There's another economic impact. If they do not face to the disease or not affected to the disease, then the mother [does not have to] take the baby all the time to the doctor, to the paediatrics. That's also saving money and is impactful.*

4.2.2.2 Maternal Mortality

A second economic impact resulting from health education is an improved maternal mortality rate. Maternal health primarily represents a social impact and is discussed in greater detail below, but it also has significant economic implications. As previously discussed, decades of war in Afghanistan has left the country with some of the worst health statistics in the world, especially in regard to women and children. In particular, the maternal mortality rate was estimated between 1,600 and 2,200 deaths per 100,000 live births, which means that the lifetime risk of maternal death in Afghanistan was approximately one in six to one in nine. Mortality rates varied regionally across Afghanistan with some regions reporting higher rates than others. In at least one mountainous region of the country, maternal mortality was found to be 6,507 deaths per 100,000 live births, which was the highest rate ever reported (Bartlett et al., 2005; Strong et al., 2005; Waldman and Hanif, 2002).

Respondents expressed that maternal death was a problem in the villages surrounding Tangi Saidan before the health clinic was established. Similar to breastfeeding, education regarding maternal health was non-existent. In particular, respondents suggested that widespread lack of knowledge, misinformation concerning proper delivery methods and unhealthy cultural practises were underlying causes. For instance, one of the CHWs described, *In the previous time [before the clinic was established], the delivery happened in a dirty place where mothers faced with various problems and were very vulnerable with getting some diseases such as Tetanus and*

other diseases as they paved the soil under pregnant woman's foot during delivery. One informant explained that birth was generally considered a dirty process so people believed it should happen in a dirty place instead of soiling a clean place. Thus, families generally did not understand the necessity of sanitation for a safe delivery.

In addition to sanitation, another commonly cited underlying issue was that deliveries normally took place in the home without the assistance of any medical professional such as a midwife. A medical staff member declared, *Yes, in the previous time, the mothers didn't take care of them[selves] well and did delivery in a dirty place without presence of midwife, but now they know how to take care of themselves during their pregnancy and how to feed their children and herself.* Further, respondents also suggested root causes included the lack of knowledge concerning necessary vaccinations (e.g. Tetanus) for women and ignorance concerning the benefits of birth spacing. For example, one of the health shura members stated, *In the past [before the clinic existed], normally women gave delivery at home without the help of a well trained CHW [midwife] ... there was no vaccines, there was no hygiene and there was no distance between birth.*

However, in recent years, the evidence suggests maternal mortality has improved in the villages served by the Tangi Saidan health clinic. For example, archival evidence (e.g. MSDEV activity reports) documents various statistics including the number of deliveries, location of deliveries and the number of maternal deaths. In a combined total of 209 live births that were performed either at the Tangi Saidan health clinic or in homes in 2012 and 2013, no maternal deaths were recorded. At prevailing maternal mortality rates (1,600-2,200 deaths out of 100,000 live births) before the health clinic was established, approximately three to five maternal deaths could have occurred during those deliveries (Bartlett et al., 2005; Strong et al., 2005; Waldman and Hanif, 2002).

One of the key informants attributes the change primarily to the health education provided by MSDEV. The informant claimed, *Women now are learning more about delivery issues. This is a main reason for reducing the mother's mortality over the years.* One of the medical staff members described how the health education has changed certain behaviours such as sanitation and hygiene, *In past when pregnant women had baby, normally they had their babies on the soft soil, or sometime they put a small mattress under her feet and had the baby on that mattress. But we let them know that soil cause tetanus a type of disease. So, we told them to put plastic on the floor and then have the baby on the plastic.* The staff member continued, *... now not only there is*

midwife in clinics but also for most of the time the CHW [midwife] can help with delivery very well. CHWs have a special box with clean materials for delivery. Also, the health worker advise women to wash their hands with soap before to help with delivery.

It is important to note that the health education has been augmented by the inclusion of a delivery room in the Tangi Saidan health clinic where medical professionals (e.g. doctors and midwives) perform the deliveries. Further, women now know it is vital to ensure midwives from the health clinic assist during home deliveries. For instance, an informant explained, *During the day when the clinic is open they come to clinic. At the clinic there is a very well trained midwife with good equipment. So all deliveries get done easily and safely. And if it during the late afternoon when clinic is not open, the rich family take the patient to Kabul and poor family give birth at home. But there is a well trained CHW [midwife] available at the village to help these ladies who give birth at home.* Because most families in the villages surrounding Tangi Saidan are poor, deliveries are normally conducted at the clinic or in homes.

Thus, health education provided by MSDEV has had a widespread social impact regarding maternal health behaviours of women served by the clinic, which has impacted families economically. For example, as previously mentioned, the lifetime risk of maternal death in Afghanistan was previously as high as one in six (Bartlett et al., 2005). Consequently, maternal death has been a common risk for many Afghan families, which includes those living in the villages surrounding Tangi Saidan. Respondents stressed that there is a lengthy mourning process in the case of maternal death. One of the medical staff members expounded the process, *If a mother die, usually there will be a formal and big ceremony and lots of people participate [in] the ceremony... ceremonies continued until 40 days. For example, each week on each Friday there will be praying, reciting Quran and etc.* As a result, families incur many expenses related to the various ceremonies.

Respondents emphasised that the financial costs associated with mourning ceremonies are very burdensome on families often requiring borrowing from relatives to pay expenses. Most respondents suggested that the cost of the various ceremonies would be at least 100,000 Afs. However, many said the cost could range as high as 300,000 Afs or more depending on the size of the family. For instance, a member of the medical staff estimated that, *For a family with a large number of relative it cost 300,000 Afs, and for a family with small number of relative it cost 200,000 Afs.* In addition, during the course of the field research, the researcher had the opportunity to attend a mourning ceremony. Informal observations and discussions revealed that the immediate

family was required to host visiting relatives, feed dozens of friends and relatives daily and participate in prayer ceremonies at the mosque. It was recognised that this mourning process would continue for 40 days. Thus, the reduction in maternal mortality through health education has represented an important economic impact for families served by the Tangi Saidan health clinic.

4.2.2.3 Family Size

A final economic impact regarding MSDEV health education is that family sizes are decreasing. This is due to the health clinic staff teaching families about family planning. They generally communicate that a small family is a happy family. Further, the staff teaches about the benefits of family planning (e.g. impact on finances, education and quality of life) and how to implement the methods (e.g. birth control and birth spacing). There are two socio-cultural and religious characteristics that must be understood regarding family size in Afghanistan. First, although respondents suggested most villagers currently practise family planning, Islamic fundamentalists were previously against it. For example, one informant explained, *They [the fundamentalists] are against this idea [family planning]. They say God gives the children and the food and everything, and 'Why you stop this? We won't stop this'. According to them this is a crime... to stop [having children].*

Because fundamentalism has diminished in this region of Afghanistan, MSDEV has had the opportunity to engage the community with new ideas. Thus, health education provided by clinic staff has had a significant social and economic impact on families. Second, it is important to clarify that it is culturally and religiously accepted in Afghanistan for men to have more than one wife. Therefore, number of children was discussed as per wife in interviews and focus groups with respondents. During the study, however, respondents claimed that the majority of men only have one wife in the villages surrounding Tangi Saidan. Thus, since most men only have one wife, it should be understood in the study that respondents are typically speaking from that perspective when reporting number of children.

As a result of the health education, the majority of respondents communicated that they no longer want large families. They suggested that families previously desired around 8-12 (or more) children, but their mentality has changed, and now families typically want between 4-6 children. Family size was a popular topic among respondents, and many compared how perspectives have changed over time since the health clinic was established. A managerial staff member stated, *In the previous time,*

most of people interested to have big size of family like 10-11 children, but nowadays they prefer to have between 4-6 children. One member of the health shura added, In the past time, most of the people were interested to have 12-13 children, but now it is reduced to 4-6 children per wife.

The majority of the customers reiterated this change in perspective regarding family size. For instance, one customer commented, *Yes, in the previous time, the people wanted to have between 10-15 children but now it is decreased to 4-5 children.* Another customer added, *I have born 11 children, but now most of the people prefer to have between 4-6 children.* Although giving birth to such a large number of children may seem excessive by developed world standards, respondents reported several examples of women who had given birth to many children. In fact, one female customer disclosed, *Now, I have 11 children and six of my babies has passed away during delivery. Totally, I gave birth for 17 times.* Overall, customers attributed the change in perspective to the health education provided by MSDEV. One customer acknowledged, *The family planning programme has really good impact because under this programme the families know how to control the births. As in the past, most families wanted to have between 8-9 children, but it is [now] reduced.*

As a result, respondents discussed two primary areas in which the MSDEV health education has impacted their lives economically – the general family budget for food and clothing and greater ability to finance education for children. First, families in the Tangi Saidan region are generally poor and find it difficult to financially sustain a large family. Thus, as a consequence of the MSDEV health education, respondents now understand that a smaller family is more economically viable than a large family. Medical staff members often illustrated the perspective they commonly share with parents. For instance, one staff member stated, *Less children give a better opportunity to their parents to take care for their hygiene, food and clothing.*

Another staff member added, *... for example with lots of children you have to buy clothes, stationary, and really expensive other things.* A member of the health shura also described that, *For example, when I had one child, I could afford to buy any toys he needed. I took him to bazaar with me. I bought juice for him and other things he wanted. But now I have four children, and I can't buy anything for them because I can't afford.* One of the CHWs explained, *It is clear that those families who have large size of the family they can't prepare good food and clothes as well as their education is challenge for their families. The small size of family don't have such problems.*

Customers confirmed that it is challenging to financially support a large family. For instance, one customer stated, *Mostly the people want to have less children as point of economy they can't afford large size of the family.* Another customer questioned, *If a person has 5,000 Afs per month, how he is able to afford the expenses of a large size of the family?* Yet, another customer added, *A small size of family is good in every aspect as we can afford to buy everything for them [children] that they need.* A key informant articulated how the thinking of parents has changed, *Because now they understood, if I have a small family I will be rich, and [have] a luxurious life and facility I can provide for my family.*

Due to a smaller family size, almost all respondents cited a greater ability to finance educational opportunities for their children. Thus, education represents the second economic impact resulting from health education provided by MSDEV. One of the members of the health shura explained, *The small size of the family can have a comfort life... We can also afford to pay expenses of their education, but for the big size families these things are impossible.* A customer also commented, *Yes, those who have less children can educate their sons very well than large size of the family.* In addition, a CHW also agreed that, *The small size of family has a high chance in educating of their children.*

Thus, respondents affirmed that parents in smaller families have a greater chance of financing education for children compared to those in larger families. For example, a medical staff member described, *Also, parents can provide schooling materials for their kids easily like paper, pens and pencils and other [things] that a school kid need, and sending them to good school. For example, I have three sons, two of them are engineer and one of them is a nurse, but if I had seven sons surely I couldn't afford to educate all of them.* With greater finances at their disposal, respondents further suggested that smaller families could provide a broader range of courses for children and access to higher quality schools. One of the medical staff explained, *For instance... I can send him to many course for different subjects and now in our country good education is not free; you have pay for that. So, if you have more kids, you need to pay more for their education.*

When asked whether there were differences in educational opportunities for children in small families compared to children in large families, several respondents claimed that smaller families would likely have a better opportunity to finance higher education for children. For example, a customer stated, *Yes, those families who have less children, they can educate their sons well as they have enough time and [can]*

afford to enroll their sons in institutions. Another customer added, *Yes, they can educate their sons up to high levels.* Therefore, respondents suggested that a smaller family size is essential for families to be able to finance the best educational opportunities available for their children such as private schools and higher education.

4.2.2.4 Summary

As discussed above, the health education services provided by MSDEV have impacted the surrounding villages economically in three primary areas – breastfeeding, maternal mortality and family size. Although these areas also represent social phenomena, each provides an important economic impact for families served by the Tangi Saidan health clinic. For instance, because families now understand the importance and benefits of breastfeeding, respondents suggested more women are breastfeeding now compared to before the clinic was established. As a result, they are able to save money by eliminating expensive alternatives such as infant formula.

Respondents further suggested (and MSDEV activity reports support) that maternal mortality rates have improved in the villages surrounding Tangi Saidan primarily due to the health education provided by MSDEV. This has been an emotional and financial relief for families served by the clinic. Finally, through its health education, the MSDEV medical staff has taught that a small family is a happy family. As a result, parental perspectives and priorities have begun to change as families have realised it is easier to financially provide for a smaller family. In particular, parents can provide sufficient food and clothing as well as better educational opportunities for children in smaller families.

In summary, the economic impact of the Tangi Saidan clinic is two-fold. Whereas the clinic visit represents cost saving for a single event, cost savings associated with health education have been realised as a result of changed attitudes and behaviours. Therefore, overall economic impact from the Tangi Saidan clinic comprises both cost savings from each individual clinic visit as well as from changes in attitudes and behaviours of community members. One of the MSDEV executives summarised the comprehensive economic impact regarding the clinic visit and health education, *Well, we all know how expensive health care is, and the closer you are to the health care services the less economic impact it has on your life. That is true here, where you have to wait a week to see a doctor in the states is the same thing. So having immediate medical care [in Tangi Saidan] has reduced the cost of medical care, and in addition*

having community health education has probably saved them by a factor of ten because it's huge.

Finally, it is important to note that economic impact and social impact are interrelated. This means that social phenomena impact economic phenomena and vice versa. While there are clear economic impacts, several of those impacts are associated with social phenomena. For example, the instance of Maharam pertaining to the clinic visit is one of the most significant social impacts that are discussed in detail below. In addition, whereas the health education has resulted in several economic impacts, the thrust of the teaching is related to social phenomena. Thus, areas such as interethnic relationships, family dynamics, maternal health and hygiene are all reflected below concerning social impact of the Tangi Saidan health clinic.

4.3 RELATIONSHIPS (SOCIAL IMPACT)

As mentioned above, economic impact and social impact are intertwined, which means that social phenomena impact economic phenomena and vice versa. Thus, several social phenomena have been previously introduced such as the cultural requirement for women to have a male escort when travelling outside of the home (Maharam), as well as changing perspectives regarding family size. However, these are primarily social phenomena and specifically impact relationships within the community. Therefore, they are addressed in greater detail below regarding the social impact of the Tangi Saidan health clinic.

During grounded theory analysis, there were two categories that emerged pertaining to overall social impact of the MSDEV health clinic – “relationships” and “behaviours”. Social impact occurred in two areas regarding the first category “relationships”. These subcategories include interethnic relationships and family relationships. The subcategory interethnic relationships describes how the health clinic has impacted the relationships across tribal groups, and the subcategory family relationships expounds on how the health clinic has impacted the relationships within families. In addition, social impact regarding “behaviours” is represented by two subcategories, which include maternal health and hygiene and first aid. The subcategory maternal health describes how the clinic has impacted the health of women, particularly relating to pregnancy and delivery while the subcategory hygiene and first aid reveals how the clinic has impacted general hygienic and first aid practises in the villages served by the health clinic.

Regarding the category “relationships”, the health clinic has had a significant social impact upon interethnic relationships in the Tangi Saidan Region. Concepts such as the role of women and impact of the shura explain the social impact upon interethnic relationships in the community. While the health clinic has impacted interethnic relationships among men and women, the clinic has had a particularly important social impact regarding the interethnic relationships between women. Further, beyond the broad social impact upon interethnic relationships, the health clinic has impacted individual families as well. Thus, the concepts family dynamics and the independence of women comprise social impact upon family relationships. Similar to interethnic relationships, the clinic also has had a notable impact upon women regarding family relationships. Together, these subcategories and concepts explain how and why the health clinic has broadly impacted relationships in the villages surrounding Tangi

Saidan. The subcategories and concepts associated with “relationships” are illustrated in the following table.

Category 2 (Social Impact)	Subcategories	Concepts
Relationships	Interethnic Relationships	The Second Public Meeting Place The Role of Women Impact of the Shura
	Family Relationships	Family Dynamics Independence of Women

Table 4.5: Category 2 – Subcategories and Concepts (SOURCE: Author)

4.3.1 Interethnic Relationships

The first subcategory is interethnic relationships, and it is comprised of three primary concepts – the second public meeting place, the role of women and impact of the shura. A table of the various categories of respondents can be found in Appendix 2, and the relative contribution by respondent category for each concept regarding interethnic relationships is illustrated in the following table.

Interethnic Relationships			
	The Second Public Meeting Place	The Role of Women	Impact of the Shura
Categories of Respondents	* Medical Staff Managerial Staff Health Shura CHW	* Medical Staff Managerial Staff Health Shura CHW Customers	Executive Staff * Past Medical Staff Medical Staff Health Shura
	* Indicates if a key informant was involved		

Table 4.6: Relative Contribution by Respondent Category – Interethnic Relationships (SOURCE: Author)

There are five main tribes that live in the Tangi Saidan region including Pashtun, Tajik, Hazara, Uzbek and Kuchi (nomadic). One of the MSDEV executive staff members explained that an approximate composition of the tribal population in the villages surrounding Tangi Saidan is 60% Pashtun, 30% Tajik, 5% Hazara and 5% other. In order to understand social phenomena in the research study, it is important to recognise that Afghanistan is broadly a tribal society, and tribalism is more predominant in the villages (compared to the cities) where 80% of the total population lives.

Consequently, in the region surrounding Tangi Saidan, relationships were predominantly divided along the various ethnic factions before the health clinic was

established. Overall, respondents acknowledged that there was little interaction between tribes and that interethnic relationships were largely non-existent, poor or even hostile at times. For instance, one of the health shura members described, *Relations between ethnics groups were not good before this clinic because they didn't see each other. If they don't see each other, how can they build relationship?* A key informant added, *For example one person was not sitting with another. Hazara was against Tajik, Tajik was against Pashtun, Tajik was against Kuchis....* As a result of a lack of interaction between tribes, there was essentially no relationship or trust among the various ethnic groups.

Many respondents further indicated that tension between tribes was common and often described that interethnic relationships were not warm. For example, a CHW commented, *The relation [between ethnic groups] was not so warm before this clinic.* Other respondents stated that various tribes could even be openly hostile toward one other. For instance, an informant alleged, *Yes, there was problems between them [different ethnic groups] such as disagreements and sometimes conflicts... in the previous time, before the clinic and training centre they would fight and were against each other.*

One of the executive staff members observed ethnic groups cursing one another as well as tribal feuds over land and water. For instance, he expounded, *I have been down there when there has been one leader calling another ethnic leader, 'you and all your donkeys'. Just cursing them, and bringing them down, and just terrible, terrible relationships going on.* He continued, *The way it plays out in that culture is that 'I am a Pashtun and you're a Tajik, and you really don't count in my book because we are the majority. We are a lot smarter, and we were created to rule over you, and Hazaras and everybody else'. They have such pride that it's like a freight train. Their pride is like a freight train. The Tajiks are not a whole lot better because they have had to defend themselves from that. So, they have adopted some of the same techniques. So, the way it would work in a place like that is they just wouldn't interact. Then you end up with these feuds over land and water.*

In addition to the lack of interaction among tribes, particular cultural values may fuel conflicts. For example, certain Afghan proverbs reveal a history of treachery and revenge in the Afghan culture. A respondent gave examples of two proverbs that illustrate these underlying cultural characteristics. The first proverb explains that, *With my lips I tell you that I love you, and under my cloak I have a dagger to plunge into your heart.* The second declares, *Today I killed the enemy of my family. It only took me*

70 years, and it's not so long. It should not be assumed that all (or even the majority) Afghans act or think this way, but cultural proverbs like these may partly explain why interethnic relationships were tense before the Tangi Saidan health clinic was established.

Moreover, it is important to note that interethnic relationships between the various tribes were often in flux before the clinic existed depending upon specific circumstances, individuals involved, issues being dealt with or conflict that had arisen. For example, one informant explained, ... *we have a total of 39 villages. Here is Hazara, here is Tajik, here is Kuchis, there is Pashtun, and there is health shura and the clinic... Now this person has this community, has this village, and has interference with this. They are not good with this. They are fine, or they are fine.* The informant was illustrating that while various ethnic groups in certain villages may be facing conflicts, others may not be experiencing any problems.

He further clarified that the frequency and level of conflict often depended upon how many ethnic groups were in an area. Although conflict was more likely to arise when a larger number of ethnic groups populated an area, conflict could even arise among family clans within a single ethnic group. For instance, the informant continued, *In some areas [there are] two ethnic groups, [and] in some areas [there is] one ethnic group. In some area [there is] one ethnic group but still they do not like each other. Ok, conflict among them or something like that.* Other respondents added that discrimination among tribes was common. In particular, if one ethnic group represented a minority within a highly populated area of a larger tribe, discrimination could be more severe because the minority has no chance of winning a dispute. For instance, an executive staff member explained, *Well, it depends on where you're at. If you go out to Jegdalek, it's almost all Pashtun out there and they dominate, and there is not a lot of fight in anyone else because you would lose any time anyway.*

In summary, it is important to illustrate what interethnic relationships were like among the various tribes living in the Tangi Saidan region before the health clinic was established in order to understand the significant impact the clinic has had upon these relationships. For instance, the majority of respondents claimed that the health clinic has caused interethnic relations to gradually warm over time. Respondents further explained how the health clinic improved relationships and why this has happened. Thus, the following concepts – the second public meeting place, impact of the shura and the role of women – explain the fundamental social phenomena concerning the how and why the

Tangi Saidan health clinic has impacted interethnic relationships among the various tribal groups.

4.3.1.1 The Second Public Meeting Place

As mentioned above, there was limited interaction between tribes before the health clinic was established, and interethnic relationships were largely non-existent, poor and even hostile at times. However, respondents repeatedly discussed how the clinic has caused a warming of interethnic relationships to occur among tribes. For instance, an informant described that, *The Tangi Saidan health clinic helped to strengthen relation among various ethnic groups and make it warmer comparing to past time*. The Dari word respondents used for warming of relationships was khob shodan. This is the same word used in Dari for the type of warming that is related to temperature. Thus, the use of the Dari word khob shodan is similar to the use of warming in English, which can be used to describe both the temperature as well as an expression of affection or kindness.

Relationships began to warm over time after the Tangi Saidan health clinic was established primarily because it provided a starting point for relationships among the various tribes. For example, one of the CHWs stated, *The relation was not so warm before this clinic, but when the people come to this clinic they knew each other and start a kind of relationship with each other*. One of the medical staff members also recounted, *... this clinic caused them [villagers from various tribes] to make it [relationships] warmer because the clinic is public place, and people from different tribes come to it. When they see each other, they talk [and] they share their stories about their life and problems. So, finally they get to know each other*.

It may seem overly simplified to suggest that the health clinic could have a significant warming affect upon interethnic relationships merely due to people meeting and establishing relationships. However, respondents argued that the clinic is very important because there are only two primary public meeting places in most villages – the mosque and the clinic. For instance, a managerial staff member described, *Yes, two places have very good impacts on people relations – one is mosque and the other one is clinics. People from different tribes come to these places, and they talk to each other and get to know each other. Finally, relationships become warmer between them*. In essence, the respondent was explaining that health clinics commonly act as a second type of public meeting place in addition to mosques.

Not only have villagers from various tribes been able to meet at the health clinic, but they have also interacted with the clinic staff. Staff members believe this interaction has improved the view ethnic groups have of each other. For example, one managerial staff member suggested, *In the previous time before establishing the clinic, they [villagers from different tribes] had some bad thoughts about each other, and we established a kind of connection between them and bad thoughts were removed from their minds.* In addition, a medical staff member described how providing equal care to all patients (regardless of ethnicity) has positively impacted interethnic relationships, *Yes, for example, at the beginning when I was new to this job and this place, Pashtun people were thinking that non Pashtun doctors treat non Pashtun patients better than Pashtun patients. In progression of time, we meet each other repeatedly and build relationships [and] then get to know each other. They realised that what they were thinking at the beginning was not true.*

It is important, however, to note that the health clinic is part of a larger community centre. As discussed earlier, the case study design is embedded rather than holistic because MSDEV operates several initiatives and ventures under the broader organisation. The Community Centre Initiative is the larger unit of analysis and the health clinic BoP venture is the primary subunit of analysis. Therefore, the other two BoP ventures – Internet/computer centre and educational services – also have some impact upon interethnic relationships.

For example, an informant described, *Yes, our clinic and training centre has had good impact, and in the previous time before the clinic and training centre, they would fight and were against each other. But by establishing the clinic and training centre, the children of two tribes would come together and study in one class. As a point of mentality, now they don't have any problems.* The informant further explained families are able to establish and build relationships with each other as a result of children studying together, ... *since this health centre established, they come to the same doctor and to the same clinic. Most important of all their children come to the same class to receive the same training, and finally they got to know each other better.*

Although the Internet/computer centre and educational services have impacted interethnic relationships, the clinic provides the greatest overall impact. For example, whereas the combined number of students taught at the Internet/computer centre and educational services may average roughly 3,000 students per year, patient visits to the health clinic can average around 16,000 or more visits per year in Tangi Saidan. In addition, a key element of the health clinic is that it involves villagers of all ages instead

of primarily youths like the Internet/computer centre and educational services. One of the MSDEV executives described that while all services provided through the various BoP ventures are valuable to the community, the clinic acts as the anchor. In other words, the clinic provides critical services most needed by families living in the villages surrounding Tangi Saidan, and as a result, it attracts the greatest number of customers. However, it is beyond the scope of the current research study to measure the comprehensive economic and social impact of the entire Community Centre Initiative or the other individual BoP ventures.

Therefore, the establishment of the clinic increased the likelihood and frequency of members from various tribal groups meeting each other and interacting in a second public meeting place. For instance, one of the medical staff members commented, *In the previous time, the people didn't have the chance to meet each other frequently, but since establishment of this clinic the people visit doctors and beside establish relation with each other.* A member of the health shura summarised how the health clinic has facilitated this new interaction among tribes and why it has ultimately resulted in warmer interethnic relationships. He explained, *Yes, there are a lot of people in Tangi Saidan that I and my family hadn't seen them [families from other ethnic groups] before this clinic, but since this clinic and the health shura haven formed we have seen several times. And as results of seeing them, we got to know them. So, now we have interaction with each other too. When women come to the clinic, they have their kids with them. Mothers talk with each other, and kids play with each other. Sometime a mother of a child give gift to the child of another woman. By this way, relationship become warmer. So, if there was not the clinic there, how could they [women] see each other?*

4.3.1.2 The Role of Women

Not only does the health clinic act as a type of second public meeting place for people living in the Tangi Saidan region, it is the only public meeting place for women. It was discovered during the course of the research that women are not allowed to go to the mosque. For instance, one member of the health shura stated, *The mosque is for men and clinic is for women.* Another member of the health shura added, *For women the clinic is a good place to talk and see each other, and for men the mosque is a good place to see each other.*

Further, one manager explained that clinics are essentially like a mosque for women, *As we know that clinics are treated as a mosque for mostly women, and the people establish their relationship by coming to this clinic.* This means that clinics

provide the primary opportunity for women in the villages to meet each other in public, which has led to relationship building among women from different tribes in the Tangi Saidan health clinic. One of the medical staff members described this phenomenon, *When the [female] patient come to the clinic, they see other women from different tribes and meet each other, and repeatedly these types of meeting happen and finally they build relationships*. Another medical staff member also affirmed, *Clinic is a good public place for women. When they see each other, they talk to each other, and then they get to know each other. Finally, they build relationship*.

Apart from visiting the clinic, women do not interact in public often. Respondents expressed that women do attend family celebrations or ceremonies with relatives. However, the ceremonies (e.g. weddings or funerals) often occur within the family or tribe, and these formal events typically do not nurture interethnic interactions. In addition, respondents suggested that there is not a lot of time during celebrations and ceremonies to build relationships. Clinics, on the other hand, facilitate both interethnic interactions and time to establish relationships. For example, one of the members of the health shura explained, *The opportunity for women to meet is in the clinic. Sometimes they will meet at a ceremony like a wedding, but most of the women are busy with music, or in that formal ceremony they are sat ethnically and they don't prefer to [talk to] people about their issues. But when they come to the clinic, they have enough time to talk and discuss the issues and establish relationships among other things, and this is why the clinic is best for the women*.

Furthermore, it was interesting that although men were able to interact in public before the health clinic was established, this did not engender interethnic relationship building among tribes. However, as soon as women had a chance meet publicly at the clinic, interethnic relationships began to improve. Thus, one key finding the research study discovered is the crucial role women have played in the warming of interethnic relationships. Respondents discussed how women (through interaction at the health clinic) have acted as catalysts for improving interethnic relationships. For instance, as previously mentioned, men have always been able to meet publicly in the mosque. However, the primary purpose of the mosque is for praying, not necessarily for relationship building. As a result, respondents claimed that most men come for prayer and leave. Elders who do not work may come early or linger after prayer and socialise, but it appears that the majority of men in the villages visit the mosque primarily for religious purposes and less for socialising.

Therefore, respondents suggested that relationship building among women at the clinic has actually improved the interethnic relationships among the men and their families. One member of the health shura said, *The clinic impact more the [interethnic] relation among women as clinic is the best place for women to meet and talk with each other. Moreover, this relation impacts the [interethnic] relation among men, but the men have more opportunities to meet each other in some ceremonies like funeral, praying ceremony and other places.* Another member of the health shura added, *Clinic is the best place for women. If relationship established between women, men will also benefit as families get together.*

Respondents also described how women tend to be much more socially oriented than men, and women more frequently share personal issues and problems with each other compared to men. For instance, one of the health shura members asserted, *Women are very tight about relations, but men are careless about relations. Also, mosques and other places that normally men meet each other are mostly formal places that they can't talk about personal things, but clinic is a very good place with very good time [for women] to talk so freely about any personal things.* Further, a medical staff member stated, *When women come to clinic they habitually share their family problems with each other, and there are old and with experience women among the customers. So, they guide the others and by this way lots of family problem got reduced.*

In addition to being more socially oriented, respondents suggested that women also tend to be more empathetic and generous than men. For instance, one of the health shura members claimed, *Most of the time we become aware about situations of other family through women because they talk a lot with each other. When there is a problem for a family in a village, women let their husbands know about that, and then whole community know about things going on. And also women encourage men to help poor people, and by this way we help each other. For the most of the time it has been seen that women are more kind than men. For instance, this morning my niece came to my house at breakfast time. I wanted to serve her tea, but my wife cooked egg for her. A CHW added, My wife asked me to give her money [to care for guests] this afternoon, and I gave her 2,000 Afs. If I denied, then she will not welcome my guests well, so this is why that family invited each other for parties.*

As a result of this open social interaction among women from the various tribes, several noteworthy phenomena have begun to occur across ethnic lines. These phenomena include women calling each other God sister, families inviting each other to ceremonies and celebrations and parents proposing interethnic marriages. For example,

one unique relational phenomenon that has been occurring among women at the Tangi Saidan health clinic is that they have begun to call each other God sisters. While this was a normal practise among close female friends within tribal groups, it was not commonplace among women from different tribes before the health clinic was established. For instance, a medical staff member explained, ... *they [women from different ethnic backgrounds] talk to each other [at the clinic], and they get to know each other and lastly they call each other God sister.*

One of the managerial staff illustrated this social phenomenon among women, *When they [women] see each other more than one time, for the next time they call each other [God] sister. Because they build relationship by talking and sharing stories about their lives and problems, no matter which tribe she comes from people think that women behaviour look like ducks. When ducks gather in a place, they start making noise as if they talk.* Female customers also confirmed this phenomenon has been occurring at the clinic. One customer commented, *Yes, we found God sister through this clinic.* Another customer added, *Yes, mostly the women are eager to find God sister for them.*

The Dari word respondents used for God sister was khahar-khanda. This word pertains to only females, and there is no equivalent expression among men. A God sister is a close friend but not blood relative, and these close friends enjoy a privileged relational status. For example, God sisters will often buy each other gifts, and they commonly welcome each other's family into the other person's home as well as invite them to most family ceremonies and celebrations. For instance, one of the CHWs described, *Women are very tight in their relationship here in Afghanistan. So, when women meet each other here for the first time, then they invite each other in different ceremonies like wedding, funeral ceremony and others.* A medical staff member also recounted, *My wife has been invited to parties by a woman who was not Pashtun, and now it is more common than before.*

As the medical staff member mentioned, it was not common to invite families from other tribes to ceremonies or celebrations before the health clinic was established. For example, an informant further explained, *Because normally people invite those who they know [to ceremonies or celebrations], if a person doesn't know the other person, how should he invite him? So, this clinic helped people to know each other, then relationships was build based on knowing each other and finally invitation came into existence based on relationships.* Thus, as interethnic relationships improved due to the interaction between women at the clinic, it became much more common among families from different tribes to give and receive invitations to various ceremonies.

For example, a female customer commented, *We usually invite each other [women from other tribes] in our wedding and sadness parties like funeral or else.* A member of the medical staff added, *Yes, because this clinic causes women and men from different tribes see each other and become familiar with each other, [they] share their problems with each other, and finally they build relationship and sometime invite each other for celebrations. For instance one guy from Pashtun tribe [name omitted] invited people from Tajik and Hazara tribes for his wedding.* One of the managers shared that MSDEV staff now even receives invitations from members of other tribes, *Yes, it happen a lot. Me and other staff of this clinic have [been] invited many time for wedding party by a family from different tribe.*

MSDEV staff members have also witnessed women from different tribes discussing wedding proposals regarding their children (arranged marriages are customary in Afghanistan, especially in rural areas). As a result, staff members confirmed instances of interethnic marriages, which were unheard of before relationships among tribes began to improve. For instance, a medical staff member described, *Even though at the beginning [when the clinic was established] I was not here, but I heard that a patient from non Pashtun came to clinic [and] children from Pashtun tribes thrown stone to them. But now their behaviour changed for good. Even marriage happened between them. A Pashtun girl married a Tajik boy.*

In addition, one of the CHWs affirmed, *Yes, moreover, we are witness of some [interethnic] wedding which resulted through this clinic, as they knew each other here and then decide to marry.* One informant illustrated what this process might look like, *Also, to the clinic some women come. For example, there is women A she has a young boy, and there is women B she has a daughter, a young daughter. When she talks and talks, she is looking for a young girl who is from a good, well reported family. And they make an introduction and when they identify, ok there is a girl, there is a... Something like that, that family is getting the address and then going back. When they are free from the clinic, you know, the parents go request for the marriage.*

Although most respondents suggested interethnic marriages have resulted primarily from relationships established at the clinic, there is evidence that the broader MSDEV community centre has impacted this phenomenon. As previously mentioned, the health clinic is part of a larger community centre, and the case study design is embedded rather than holistic. Thus, one informant noted that the other two BoP ventures – Internet/computer centre and educational services – do also have some impact upon interethnic marriages. The informant stated that he has witnessed boys and

girls meeting in training courses and then the parents later pursued marriage plans. For instance, he said, *Yes, there are some training courses, and the boys and girls meet each other and then they propose for their fathers for some kinds of engagements.*

There are cultural implications that may occur as a result of interethnic marriages. A medical staff member discussed how these marriages may cause cultural traditions to blend and tribes to respect one another more. In particular, some tribes have more strict rules regarding the interactions of engaged couples. The staff member described, *... a Pashtun boy who has a fiancée he is not allowed to see her or go somewhere for shopping [with her], and also the girl is not allowed to see her fiancé. But Tajik boys and girls are more free to see each other and go somewhere.* Thus, she believes young, interethnic couples may experience more freedom as they adopt desirable customs of the other tribe. For instance, she claimed, *Surely their behaviour will get better because from their own experience from their engagement duration. [If] they have bad experience, [then] they don't want it for their sisters and brothers.*

In summary, women have played a central role in warming interethnic relationships among tribes in the villages served by the Tangi Saidan health clinic. For instance, whereas men have been able to meet publicly in mosques, the health clinic is the only public meeting place for women in the villages. Further, women tend to be more socially oriented, empathetic and generous compared to men. Now that women from different tribes have been meeting and building relationships at the health clinic, this has engendered various social phenomena such as interethnic God sisters, invitations to ceremonies and celebrations of different tribes and interethnic marriages. As a result, the warming of interethnic relationships has accelerated in the Tangi Saidan region.

4.3.1.3 Impact of the Shura

As discussed above, the clinic has acted as a second public meeting place for families, and it is the only public meeting place for women. Consequently, women have played a crucial role in warming ethnic relations among tribes. However, as a tribal society, village elders play a leading role in making decisions and resolving conflict within and between villages and tribes. Village elders typically fulfill these roles through participation on a shura, which is a general word in Afghanistan for council or committee. When the word shura refers to a council at the village level, it can be generally analogous to a city council. For example, Singh et al. (2012) refer to shura as a village council and explain that a shura should represent community interests and

ensure equity and justice to villagers. However, the word can also be used for different types of councils or committees at various levels within Afghanistan. Further, like a council or committee, each shura has a distinct purpose, and village elders may participate in one or more shuras.

One of the MSDEV executive staff explained the general use of the word, *Shura means council, or committee, or I think you understand shura. So there is a shura that oversees the entire district. Then there is probably a shura for sub districts within a district. So when we use the term shura we are referring to medical [health] shura or sometimes referred to as a medical centre shura.* Thus, various local shuras were common throughout the villages surrounding (and including) Tangi Saidan before the health clinic was established. The problem was that, as previously discussed, tribes did not interact much with each other and interethnic relations were poor. As a result, respondents indicated that participation on local shuras reflected the ethnic factions and did not promote common interaction between tribes.

However, because of the diverse ethnic population living in the villages surrounding Tangi Saidan, the MSDEV executive staff believed they would need buy-in and participation from village elders across ethnic lines for the clinic to be successful. One of the executives described the original plan to involve village elders, *So, what we tried to do initially was to have a shura that would be made up of 39 people on the Shura, but somebody who would represent more than one village. They would represent more than one village so there was good representation by all of the villages. We sought advice and counsel from the village elders as to who should be on the shura, who they would like to see on it.* He further explained that the MSDEV team told the village elders that they wanted to learn from them in order to create something that is culturally relevant and effectively able to meet the needs of the people. For instance, the executive continued, *... we are going to learn with you, how best to operate it [the health clinic] so it works for you. We are going to be with you as a shura to guide and influence.*

To ensure proper representation, MSDEV staff travelled to all 39 villages to work with village elders and recruit members for the health shura. As the MSDEV team travelled to the villages, they sought out the most influential elders called Maliks. One key informant explained the term Malik, *Ok, Malik is a person who is in charge of the village and who represents the village to the next party or to the second party or through someone. That's called a Malik. Malik is a well influenced man in the community, in that village, who has more power. He's rich, he's rich and has more sons and more power in the village.*

A Malik may even represent two or three villages depending on the size of the village and level of his influence. For instance, MSDEV eventually was able to recruit 16 Maliks (representing the 39 villages surrounding Tangi Saidan) from different ethnic groups to agree to be a part of the health shura. The informant added, *As I mentioned to you before, two to three villages, the well influenced people. We talk about well influenced person. Like there is a small village. It may be under the rite of a big village. They may have one Malik but still is not powerful. We pick up the well influenced man, and we made around 16 people. This shura has around 16 members in Tangi Saidan.*

Thus, MSDEV was able to recruit some of the most influential village elders from the surrounding villages to participate on the health shura. Although the various village elders were previously ethnically divided, relationships began to warm as they worked together to jointly improve health issues facing their communities. The informant described this positive relational change, *I saw it. I witnessed, but when you establish this [health] shura, I saw the impact. You know [the] same person who was before and who was against, and [now] they were coming, they were having, they [were] laughing, they were discussing, they were making jokes, [and] they were making their tea party.*

Because MSDEV was able to recruit influential village elders representing every ethnic group, the health shura has had a substantial warming affect on interethnic relationships in the villages surrounding Tangi Saidan. In particular, there were two underlying elements discovered during the research study that explained this impact. First, the local shuras in the villages were traditionally somewhat isolated from outside ideas with no external impetus to change before the clinic was established. However, as the MSDEV team built relationships and recruited village elders, they were able to influence traditional biases against working with neighbouring tribes.

One of the MSDEV executives explained this difficult process, *So, we have worked together through all kinds of just terrible challenges there in Tangi Saidan. I have coached him [Afghan leader that recruited village elders] in the way I want it to be [interethnic cooperation]. He in his own volition, you can see that he has such compassion for his people. He could be doing anything he wants to in life, and he's been doing this. And what he's done is talked to all these guys and said, 'Come on, let's not be like that anymore. We don't have to be that way. This is your place, and now you need to deal with it with respect'. Thus, it was the external intervention that initially influenced village elders from different ethnic backgrounds to begin working together.*

Second, whereas the local shuras in the Tangi Saidan region traditionally had representation by a single tribe at the village level, the health shura had representation from every ethnic group across 39 villages. One of the informants described this phenomenon, *In Tangi Saidan, there is different ethnic groups in there [such as] Hazara, Tajik, Pashtun, Kuchi and all those types. But [after] the existence of the clinic, what happened? They connect. Because when you have the clinic, there is a shura that comes in, and a [health] shura is established. When the [health] shura is established, the shura consists of different ethnic groups. There is Hazara [and] there is Tajik, there is, ok. And then there is well in part the clinic has to bring together the different ethnic groups.*

Respondents confirmed that the health shura involves members from all tribal groups and includes broad representation that covers the villages served by the clinic. In fact, one of the medical staff members acknowledged that this was the first time such a diverse representation of people had been assembled, *For the area of health, yes I can say that the health council [shura] for the first time combined all people from different villages by having member from each village.* The same staff member further stated, *Yes, in Tangi Saidan, we have a health shura formed from different ethnic [groups] like Tajik, Pashtun, Sadat [small ethnic group related to Pashtuns and Tajiks] and Hazara. The said shura strengthen the relationship among the said ethnic groups.* In addition, a member of the health shura affirmed this broad representation, *For example, in shura that I am one of its members, there are Pashtun, Tajik and Hazara.*

As mentioned above, one reason a shura with diverse representation can have such great social impact on interethnic relationships is that the members are influential leaders of their respective communities. For instance, one of the health shura members illustrated this phenomenon, *Because the members of Shura work together, they share their ideas with each other and they have shared problems, shared happiness and shared sadness. So, these much things make them unity and most important of all each member of shura is so respected person for his followers. When the [health shura] members are warm with each other, it surely impact on their followers.* Thus, when village elders from different ethnic groups decided to work together, this impacted the mentality of the entire community. The health shura member continued, *The role of shura in improving relationships between different tribes is a key role because it is the members of shura that are in contact with each other and making decision, working for goodness of their follower. So, when relationships between the members of shura are warm and friendly, it impact on the whole community.*

During interviews and focus groups, respondents further expressed how the health shura, through its comprehensive representation, has had a significant warming affect upon interethnic relationships in the villages surrounding Tangi Saidan. One of the medical staff members stated, *This clinic has a good impact on their relationships because there are representative from each tribe in the health council [shura]. When they come together to discuss about some problems, in the meantime they get to know each other... Moreover, the health shura also helped a lot in strengthening of [interethnic] relation among people.* Another medical staff member added, *Yes, the clinic had a good impact in strengthen of the relationship between different ethnic groups in Tangi Saidan because the health council [shura] had its member from various tribes and this itself bring unity among people there.*

In conclusion, Afghanistan has traditionally been a tribal society, especially in the rural villages. As a result, village elders have played a leading role in decision making and conflict resolution. This role is typically fulfilled through participation on a shura, which is equivalent to a council or meeting. The MSDEV team appropriately recognised this tribal custom before establishing the health clinic in Tangi Saidan. Therefore, they sought the guidance and participation from elders representing the villages that would be served by the clinic. This resulted in a significant warming affect upon interethnic relationships across tribes in the Tangi Saidan region. Subsequently, there were two underlying phenomena that explained the social impact of the health shura – external influence upon the traditional mindsets of village elders and broad representation on the health shura from every ethnic group across the villages served by the health clinic.

4.3.1.4 Summary

In summary, the first subcategory, interethnic relationships, is comprised of three primary concepts – the second public meeting place, the role of women and impact of the shura. In order to comprehend social impact, it must be understood that Afghanistan is traditionally a tribal society, and tribalism is more predominant in the villages (compared to the cities) where 80% of the total population lives. In the region surrounding Tangi Saidan, relationships were predominantly divided along the various ethnic factions before the health clinic was established. Consequently, respondents admitted that there was little interaction between tribes and that interethnic relationships were largely non-existent, poor or even hostile at times.

However, the health clinic has had a significant positive impact upon interethnic relationships in the Tangi Saidan region. For instance, the health clinic has acted as a type of second public meeting place for villagers, and it is the only public meeting place for women. This has led to relationship building primarily among women from different tribes in the Tangi Saidan health clinic. Due to open social interaction among women from various tribes, several interesting phenomena have begun to occur across ethnic lines. These phenomena include women calling each other God sister, families inviting each other to ceremonies and celebrations and parents proposing interethnic marriages. Thus, women have played a crucial role in improving interethnic relationships, which was one of the most significant discoveries during the course of the research study.

Finally, as a tribal society, village elders play a leading role in making decisions and resolving conflict within their respective communities, and they typically fulfill these roles through participation on a shura. The MSDEV team recruited village elders from every ethnic group representing the villages served by the clinic and leveraged external influence to engender cooperation, which has had a significant positive impact upon interethnic relationships. Thus, each of the concepts – the second public meeting place, the role of women and impact of the shura – have jointly caused a warming of interethnic relationships to occur among tribes in the villages served by the Tangi Saidan health clinic.

4.3.2 Family Relationships

Although the greatest relational impact concerns interethnic relationships among tribes, the health clinic in Tangi Saidan has also impacted family relationships. This is the second subcategory, and it comprises the concepts family dynamics and the independence of women. A table of the various categories of respondents can be found in Appendix 2, and the relative contribution by respondent category for each concept regarding the family relationships is highlighted in the following table.

Family Relationships		
	Family Dynamics	The Independence of Women
Categories of Respondents	* Medical Staff	Medical Staff
	Health Shura	Managerial Staff
	CHW	Health Shura
	Customers	CHW
		Customers
	* Indicates if a key informant was involved	

Table 4.7: Relative Contribution by Respondent Category – Family Relationships (SOURCE: Author)

As discussed above, social and economic impacts are intertwined such that social phenomena impact economic phenomena and vice versa. Thus, while family dynamics and independence of women primarily characterise social impact regarding the health clinic, the social phenomena have also resulted in various economic impacts, which were explained above.

The two concepts – family dynamics and independence of women – explain how the health clinic has impacted relationships within the family. Family dynamics have changed primarily as a result of the clinic staff providing family planning services. On the other hand, women have begun to experience greater independence as a result of the overall high quality of services provided at the clinic and the trust the clinic staff has established with families living in the surrounding villages. Consequently, the health clinic has impacted various social phenomena such as the number of children desired by parents, the aspirations of family members and the way families interact.

4.3.2.1 Family Dynamics

As previously discussed, the MSDEV medical staff not only teaches about how to implement family planning methods (e.g. birth control and birth spacing), but they also promote the benefits such as impact on finances, education and improved quality of life. In addition, they generally teach that a small family is a happy family. Consequently, most respondents communicated that they want less children. This was explained earlier within family size regarding economic impact of the health clinic. Although the economic impacts concerning family planning have previously been discussed, it is important to also understand the various impacts upon social phenomena.

For instance, respondents now view the ability to have smaller family size as a primary means to attain a better, more enjoyable life. As previously mentioned, a customer acknowledged, *The family planning programme has really good impact because under this programme the families know how to control the births. As in the past, most families wanted to have between 8-9 children, but it is [now] reduced.* One of the CHWs added, *People now don't prefer to have big size of the family, and this can be controlled by having some contraceptives like condoms, tablet, injection.*

Because community members now understand the methods and benefits of birth control, families have begun to develop new ambitions and aspirations. One key informant emphasised the social impact family planning has had on the mentality of people served by the health clinic, *... they like family planning, they use family planning and... the social impact is according to the people's minds. It's not just economic.*

Therefore, the change in mentality has impacted the family size and relationships. For instance, most respondents claimed to desire a better life. Besides having greater disposable income and savings (economic impacts), respondents explained that a better life means having a household that is easier to manage, providing more educational interaction with children, enabling a more active social life and offering greater opportunity for travel and sightseeing.

First, several respondents discussed how a large family with many children tends to be exhausting and difficult to manage. According to respondents, a smaller family can make it easier to raise children and leads to a less stressful and more comfortable lifestyle. For example, one of the members of the health shura described, *Yes, even we give them [parents] examples how life is comfortable with less children and how difficult is with more children especially in terms of economy.* Respondents often mentioned normal family functions that are impacted by having a smaller family including household chores (e.g. food preparation, cleaning), raising children, stress of providing basic provisions such as food and clothing (related to economic impact), family conflict and helping children with school lessons. For instance, one medical staff member stated, *If you have a small number of children you can manage [the household] better....* Another staff member added that, *... in general, it is easy to raise less children with good behaviour and good manner.*

Second, respondents explained that a smaller family size impacts how parents interact with children regarding education. While parents did identify that the ability to finance education for children (previously discussed regarding economic impact) is impacted by family size, respondents also frequently expressed that they would like to spend more time helping children with lessons. However, they complained that spending enough time to help each child with schoolwork in a large family is simply not possible. For instance, one of the customers said, *In large size of the families, the fathers don't have enough time to help their sons in their lessons.*

Having fewer children, on the other hand, allows parents to spend sufficient time with each child to help them with schoolwork. For example, one of the members of the health shura claimed, *At the present time, the people prefer to have less children to have enough time for them and educate them well.* Another health shura member added, *... if we have less children, we will be able to educate them well and help them in their lessons.* One medical staff member described how a small family size has enabled her to spend ample time helping her child with schoolwork, *For instance, I have one child.*

Every day I can check with him [to see] if he doesn't have problems with his daily lesson....

Finally, many respondents expressed the desire to have an active social life. However, they explained that large families have a more difficult time attending ceremonies and celebrations compared to smaller families. For instance, a customer stated, *Beside economic reason, nowadays those who have lots of children are not invited to some parties such as wedding and other ceremonies.* One of the CHWs added, *If a family [has] less children, all families are eager to invite them in the parties because of having less children.* A member of the medical staff explained part of this rationale, *Inviting a big family cause more work and more expenses for the host/inviter. Most of the time for this reason they are not invited as often as a small family is invited.*

In fact, when large families are invited to celebrations, the entire family may not be able to go. It is possible that only part of the family will attend, which may lead to family conflict among siblings. For instance, a medical staff member described that, *If a family has a lot of children and you want to go somewhere as a guest, the family does not want many children. They always prefer a family with a small amount of children. For example, if I took eight sons, four of them will raise conflict. Sometime in Afghanistan it is not possible to take all of your sons there, and if you have eight children you should take four of them and the other four will be at home. So a conflict will be raised among the children, who should go and who should not go.*

Finally, a few respondents pointed out that smaller families have a greater opportunity to take picnics and travel, or go sightseeing. Respondents illustrated social and economic reasons for the increased mobility enjoyed by smaller families. For instance, a medical staff member compared her personal situation with that of her sister's family, *My sister has eight children, and she is very busy so she can't go anywhere for sightseeing. And I have one child, [and] I can go everywhere I want.* However, as can be expected, finances also play a role regarding travel and sightseeing. When asked whether family size impacts how a family is able to enjoy life, a different staff member added, *Yes, because a small family can save the money and use it for sightseeing....*

In summary, now that families know how to use birth control and understand its benefits, parents typically want fewer children and have envisioned new aspirations for a better life. As a result, family dynamics have begun to change. Respondents suggested a better life may include a household that is easier to manage, greater educational interaction with children, an active social life and opportunities for travel and

sightseeing. One of the medical staff members summarised this impact on family dynamics, *It is clear those who have a small size of family are very happy and enjoy from life better than those who have a big family size, because the small size of family can go everywhere [for social events and sightseeing] easily and their parents can educate them well.*

4.3.2.2 Independence of Women

Not only has the health clinic impacted families, but it has also had a unique social impact upon women. As previously discussed, it is a common cultural requirement in Afghanistan for women to be accompanied by an escort, or Maharam, in order to travel outside their home residence. This individual must be the woman's husband or a male relative such as father or brother. Thus, this requirement for Maharam is also typically necessary when women seek medical treatment at health facilities in Afghanistan. Some studies even reveal that this cultural practise (Maharam) is a common barrier to women receiving proper health care in Afghanistan (Reilley et al., 2004; Singh et al., 2012).

However, as mentioned previously, the research study discovered a very interesting phenomenon regarding this cultural practise in the villages surrounding the Tangi Saidan health clinic. It found that while a male (relative) escort would be necessary for women (including instances where women take children to the clinic) to seek medical attention in Kabul, Maharam is not required for women to visit the Tangi Saidan clinic. This discovery stands in contrast to the literature and what appears to be customary across most of Afghanistan. As a result, it was a significant finding that occurred during the course of the research.

During interviews and focus groups, respondents frequently described this phenomenon as a notable social impact resulting from the health clinic in Tangi Saidan. One of the CHWs exclaimed, *As a point of social impact, the people can easily go to this clinic, especially women without having a Maharam.* Many respondents also contrasted the phenomenon occurring in Tangi Saidan with the situation in Kabul. For instance, a different CHW stated, *The women can refer to Tangi Saidan clinic alone without any companion [Maharam], but if there is no clinic in Tangi Saidan, then they should go with their Maharam to Kabul for treatment.* One member of the health shura added, *The patients don't need for Maharam when they come to Tangi Saidan health clinic, but for Kabul they do.* Customers also acknowledged the contrasting situations in Tangi Saidan and Kabul. One female customer affirmed, *We don't need for Maharam*

when we come to Tangi Saidan health clinic, but if we go to Kabul, we need to go with Maharam.

Direct observations conducted at the health clinic also verified this phenomenon. For instance, during the morning hours, there was normally a steady stream of women and children filing into the health clinic. The women mostly arrived by walking to the clinic, and there were no men accompanying them. There were a few men that visited the clinic, but they were seeking care rather than accompanying women. Consequently, although respondents claimed that women must have Maharam to visit health facilities in Kabul, the evidence from interviews, focus groups and direct observations revealed that women do not need Maharam to visit the health clinic in Tangi Saidan.

As stated earlier, this phenomenon occurring in the villages surrounding Tangi Saidan is not consistent with the cultural norm across much of Afghanistan or what was discovered in the literature. Therefore, it is necessary to understand why this unique phenomenon has occurred. Respondents indicated several reasons explaining why Maharam is not needed to visit the health clinic in Tangi Saidan including proximity of the clinic, perceived safety of the clinic, familiarity with the clinic and staff and trust the medical staff has established with families from the surrounding villages.

First, respondents identified distance and safety as important factors concerning the need for Maharam. For example, respondents explained that visiting health clinics in Kabul requires travel over a relatively long distance. Conversely, Tangi Saidan is situated in close proximity to all the villages. As previously mentioned, transportation was one of the greatest economic impacts cited by respondents. Whereas the majority of patients are able to walk from the surrounding villages to the clinic in a relatively short amount of time, respondents consider Kabul too far and dangerous to walk.

In addition to the travel required to visit medical facilities in Kabul, respondents were also concerned about various safety issues common in Kabul such as traffic, thieves and suicide bombers. For instance, a member of the health shura stated, *Tangi Saidan area is a village area and normally it is not as risky as city area is... in the city there are robbers who grab the bag of people on the street and ran away, but in village area there are not such bad people.* As a result, respondents emphasised the need for Maharam when women travel to Kabul. One of the CHWs explained, *Culturally we don't like to treat our wife in a far way place like going to Kabul and other places, but when the women came here [Tangi Saidan health clinic], they know that here is a safe place for them as point of security and other issues like air pollution.*

Second, respondents expressed that they have become very familiar with the Tangi Saidan health clinic. Women are familiar with the location of the health clinic and can easily walk to the clinic. Respondents explained that women do not need Maharam to travel to the Tangi Saidan health clinic due to the familiarity of the clinic and its surroundings. For instance, one of the medical staff described, *Because they [female patients] know where the clinic is [located], and also nothing is unfamiliar to them. So, they know all people at the clinic and it's around.* A member of the health shura added, *... when a woman comes to Tangi Saidan clinic, normally she doesn't need a Maharam because nothing and nobody is unknown and unfamiliar to them. It means that everybody knows everybody in Tangi Saidan area. Mostly they come to the clinic with two or three other woman too.* Therefore, women are not afraid to travel to the clinic by themselves, and men are comfortable allowing women to visit the clinic without assistance of Maharam.

On the other hand, most villagers do not frequently travel to Kabul, so they are unfamiliar with travel around the city. As a result, respondents expressed concern regarding women determining the location of the appropriate medical facilities as well as generally navigating the city. Respondents further pointed out that some women are illiterate, which may complicate identification of the health facilities and travel around Kabul. One of the members of the health shura described the situation, *For example, in the city [Kabul], addresses for clinic or other places are not easy to find, but here in Tangi Saidan the address for clinic is so easy for everyone to find.* Another health shura member added, *As we know that most of the women are not familiar with Kabul city and hospitals there. So, they need a companion [Maharam] to come with them.*

Finally, respondents stressed that trust is an important factor when seeking health care. Respondents tended to communicate a general mistrust of medical staff in Kabul. This is partly due to the fact that relationships in Afghanistan are essential for establishing trust, and most people living in the villages simply do not know medical professionals in Kabul. For instance, one of the health shura members explained, *Normally, patients don't know anybody at clinics in Kabul, [and] everybody and everything is stranger to them. Therefore, they don't trust strangers.*

As a result, villagers tend to be wary of the medical attention they might receive from health care professionals they don't know, and often perceive that they will receive better care from someone they know. A CHW illustrated this phenomenon, *My cousin irrigated his land, and due to hard work during the night he got serious sickness. Then he went to Kabul for treatment, and the doctor gave him some check up test in order to*

know whether he has malaria or not. And he spent about 1,300 Afs, but his sickness was getting worse by passing each day. When he refer to me, I gave him some medications... and then he got better within two days.

Several respondents expressed further frustration with seeking health care in Kabul because staff members at medical facilities such as doormen, nurses, doctors and ticket distributors may demand gifts (nazrana). This was explained in detail under economic impact, but it is also important to note that this practise exacerbates the mistrust patients feel toward medical staff in Kabul. For instance, a customer was upset that, ... *those who are working with doctors as a ticket distributor, the people give them money in order to get a good ticket number to visit the doctors sooner than others.* One of the medical staff members also complained, ... *in Kabul if you don't give something to the doorkeeper of the clinic or hospital, he doesn't allow you even to enter the hospital.*

In Tangi Saidan, however, patients know the medical staff very well, and trust that they will receive proper medical attention without the staff demanding gifts. Some individuals on the medical staff have even been employed at the clinic since its inception. For instance, the primary doctor and one of the vaccinators have been on the medical staff since the clinic began operations in Tangi Saidan. One of the managers described the trust that exists between medical staff and patients, *The reason is that most of health staff here at this clinic have worked for a long years. So, people know them very well, even people have the exact recognition about their personal character. So, based on this knowing, they fully trust them and have built good relationships.* Thus, relationship building has been foundational regarding establishing rapport and trust with patients served by the health clinic.

Establishing trust with villagers was not achieved immediately. Rather, the MSDEV medical staff built relationships with the patients living in the surrounding villages and earned their trust over time. Although some villagers initially thought that they might be discriminated against based upon ethnicity, they eventually built relationships with the staff and trust developed over time. A medical staff member illustrated this point, *Yes, for example, at the beginning when I was new to this job and this place, Pashtun people were thinking that non Pashtun doctors treat non Pashtun patients better than Pashtun patients. In progression of time, we meet each other repeatedly and build relationships then get to know each other. They realised that what they were thinking at the beginning was not true.*

In summary, there are many contributing factors that explain why women have gained relatively greater independence in the Tangi Saidan region compared to other areas of Afghanistan. The various factors include the close proximity of the health clinic, perceived safety of the clinic, familiarity with the clinic and staff and trust the MSDEV staff has built with community members over time. It is also important to keep in mind that the health clinic is considered the only public meeting place for women living in the villages. As a result, not only do women now have a common location where they can meet publicly in the villages, but they can also meet independently of Maharam. Thus, one of the greatest social impacts discovered by the research study is the positive impact the clinic has had upon the independence of women. This may not seem particularly noteworthy to the casual observer from a Western country. However, in a country that has been historically known for the suppression of women's rights, this positive impact upon the independence of women is significant.

4.3.2.3 Summary

As described above, the health clinic has broadly impacted relationships in the villages surrounding Tangi Saidan. Social impact of the clinic includes both interethnic relationships and family relationships, which represent the two subcategories regarding "relationships". The concepts family dynamics and the independence of women fall within the second subcategory family relationships. Social impact regarding family dynamics has occurred because MSDEV medical staff not only teaches families how to implement family planning methods (e.g. birth control and birth spacing), but they also promote the benefits (e.g. impact on finances, education and quality of life). For instance, the medical staff teaches that a small family is a happy family.

As a result, respondents have begun to express a desire for a better life, and they explained that a better life means having a household that is easier to manage, providing more educational interaction with children, enabling a more active social life and offering greater opportunity for travel and sightseeing. This has fundamentally impacted family dynamics in many ways such as family size and the ways families interact (e.g. less stress managing the household and raising children, sufficient time to help children with schoolwork).

Although the health clinic has impacted the entire family, it has also had a unique impact upon women. For instance, women have begun to experience greater independence as a result of the overall high quality of services provided at the clinic and the trust the medical staff has established with families living in the surrounding

villages. Consequently, the clinic has had a twofold impact upon women – the clinic acts as the only public meeting place for women in the villages and women can travel independent of Maharam. This has resulted in a significant positive impact upon relationships among women throughout the Tangi Saidan region. In conclusion, the health clinic has had both direct and indirect social impact upon relationships. Direct impact is associated with the family planning teaching and trust the MSDEV medical staff has established with the community, and indirect impact has occurred because the health clinic happens to be the only public meeting place for women in the villages surrounding Tangi Saidan.

4.4 BEHAVIOURS (SOCIAL IMPACT)

As discussed above, there were two categories that emerged during grounded theory analysis relating to overall social impact of the MSDEV health clinic – “relationships” and “behaviours”. The first category was comprised of the subcategories interethnic relationships and family relationships. Interethnic relationships explained how the health clinic has impacted the relationships across tribal groups, and family relationships described how the health clinic has impacted the relationships within families. In particular, family planning was one factor that has directly impacted family relationships. However, it is important to note that the Tangi Saidan health clinic staff not only provides patients education about family planning, but they also teach about maternal health issues, general hygienic practises and first aid.

As a result, the health clinic has had a positive social impact upon behaviours of people living in the villages surrounding Tangi Saidan. Thus, the final category that emerged during grounded theory analysis is titled “behaviours”. Social impact occurred in two areas regarding “behaviours”, which are characterised by the subcategories maternal health and hygiene and first aid. The subcategory maternal health comprises several concepts including birth control and spacing, antenatal care and birth and delivery.

Birth control and spacing are interrelated areas that have been impacted by the health education provided by the MSDEV medical staff, and this concept reveals insights concerning how the mentality (and subsequently behaviours) of families has changed concerning the frequency and number of births desired. Maternal health has also been impacted as the clinic staff has educated mothers about nutrition, working during pregnancy and vaccinations. Furthermore, the concepts birth and delivery comprise various social phenomena that have impacted overall maternal health including greater knowledge of the overall birth process, involvement of trained medical professionals and improved delivery methods.

Finally, the subcategory hygiene and first aid describes general hygienic practises taught by the clinic staff as well as the teaching and provision of first aid at the clinic. Various hygienic practises taught by the clinic staff include hand washing, water and toilet usage, cleaning vegetables and handling garbage. Teaching patients about general hygiene is an important element of the preventative services provided by the health clinic, and first aid generally explains how the health clinic has positively impacted the traditional practise of dressings wounds. The subcategories and concepts associated with “behaviours” are illustrated in the following table and describe how and

why the health clinic has broadly impacted behaviours of people living in the Tangi Saidan region.

Category 3 (Social Impact)	Subcategories	Concepts
Behaviours	Maternal Health	Birth Control and Spacing Antenatal Care Birth and Delivery
	Hygiene and First Aid	General Hygienic Practises Treating of Wounds

Table 4.8: Category 3 – Subcategories and Concepts (SOURCE: Author)

4.4.2 Maternal health

As previously mentioned, several decades of war in Afghanistan have left the country with some of the worst health statistics in the world, especially regarding maternal health. In particular, the maternal mortality rate was extremely high. It was estimated between 1,600 and 2,200 deaths per 100,000 live births, which means that the lifetime risk of maternal death in Afghanistan was approximately one in six to one in nine. However, mortality rates varied regionally across Afghanistan with some regions reporting higher rates than others. For instance, in at least one mountainous region of the country, maternal mortality was found to be 6,507 deaths per 100,000 live births, which was the highest rate ever reported (Bartlett et al., 2005; Strong et al., 2005; Waldman and Hanif, 2002).

Similarly, respondents expressed that poor maternal health was an issue in the villages surrounding Tangi Saidan before the health clinic was established. Although several factors contributed to the abysmal maternal health statistics, one chief problem was that maternal health education was basically non-existent in the Tangi Saidan region. As a result, respondents suggested that widespread lack of knowledge, misinformation concerning proper delivery methods and unhealthy cultural practises were root causes of poor maternal health. Due to this situation, MSDEV has focused on improving the health of mothers served by the Tangi Saidan health clinic through providing maternal health education and services.

The positive social impact has primarily occurred as a result of the teaching the clinic staff provides for women and their families. Maternal health education includes topics such as nutrition, working during pregnancy and vaccinations. However, the impact on maternal health has been further magnified because the health clinic has a delivery room where trained medical staff performs deliveries for women living in the

villages. As a result, the social impact regarding maternal health has been realised through a combination of health education and services, and the impacts are illustrated by the following concepts – birth control and spacing, antenatal care and birth and delivery. Thus, the concepts below explain various social phenomena such as the frequency and number of births desired by women, past and present delivery methods and handling complications during pregnancy. A table of the various categories of respondents can be found in Appendix 2, and the relative contribution by respondent category for each concept regarding maternal health is illustrated in the following table.

	Maternal Health		
	Birth Control and Spacing	Antenatal Care	Birth and Delivery
Categories of Respondents	* Medical Staff	Medical Staff	* Executive Staff
	Health Shura	CHW	Managerial Staff
	CHW	Customers	* Medical Staff
	Customers		Health Shura
			CHW
	* Indicates if a key informant was involved		

Table 4.9: Relative Contribution by Respondent Category – Maternal Health (SOURCE: Author)

4.4.2.1 Birth Control and Spacing

As previously discussed, respondents suggested that family sizes are decreasing. This is primarily due to the health clinic staff teaching families about family planning. For example, it has been pointed out that the staff generally communicates that a small family is a happy family. Further, they teach about the benefits of family planning (e.g. impact on finances, education and quality of life) and how to implement the methods (e.g. birth control and birth spacing). The benefits of family planning and impact upon relationships have been discussed in previous sections. However, it is also important to discuss specifically how family planning has impacted behaviours such as using birth control and spacing births.

Birth control, one of the primary family planning methods promoted by the medical staff, simply was not practised before the Tangi Saidan health clinic was established. There are socio-cultural, religious and practical reasons for this phenomenon. For instance, it has been mentioned that Islamic fundamentalists were against family planning. One informant explained, *They [the fundamentalists] are against this idea [family planning]. They say God gives the children and the food and everything, and 'Why you stop this? We won't stop this'. According to them this is a crime... to stop [having children]*. As a result, it was the cultural norm not to implement

any form of family planning, especially birth control. When asked how many people implemented family planning methods before the health clinic was established, the informant further exclaimed, *Zero, because the most people [living in the villages] religiously were against us. They thought that it is against Islamic laws to stop increasing the number of the subject [children] of God.*

However, as the clinic staff taught about the benefits of family planning and impact of birth control and birth spacing on maternal health (e.g. reduced maternal mortality, greater ability to breastfeed), it is clear that the behaviour of families living in the Tangi Saidan region began to change. For instance, one of the health shura members explained that birth control and spacing has helped reduce maternal mortality, *In the previous time, the mortality rate was high, but now it is reduced because most of the women nowadays use the contraceptives and observe birth control.* A CHW agreed that, *If the women observe the distance of birth, they will bear sound baby and the chance of mother's death is decreased. But in case of not observing the birth distance, they may bear disabled baby and the chance for losing of mothers will be high.*

In addition, some respondents suggested that failure to use birth control or observe proper birth distance increased the difficulty for mothers to breastfeed children. One of the members of the medical staff explained, *Normally, people are very happy about the methods of family planning because when there wasn't any family planning methods, there were lots of women that they couldn't breastfeed their child more than six months due the next pregnancy happening.* Respondents further described that the reason there were maternal health problems before the clinic was established was that women typically gave birth virtually every year during childbearing years. For instance, one of the medical staff members claimed, *There was no distance between births [before the clinic was established]. Even most of women became pregnant in six months after each birth.* Another staff member added, *In the past, usually a mother had a baby [in] one year [after the previous birth], but now at least there is two to three years distance between each birth.*

However, respondents believed that behaviours began to change as a result of the teaching provided by the clinic staff. For instance one of the medical staff members declared, *The patients are being told to observe the distance between birth, and this means that they should have birth at least every three years.* Further, the medical staff explained that they have instructed families how to use birth control. For instance, one of the CHWs described, *It is clear that in the previous time, the people didn't observe birth control, but now the people know that it is good to observe it.* Yet, another CHW

said, ... *Moreover, the people are [now] using the tablets, Condom to control their births.*

A medical staff member recounted that he has witnessed annual growth in women requesting pregnancy tests, which he believes reveals continued positive impact of the family planning education. For instance, he stated, *Family planning has very good impacts on birth control, specially by using condom. In the past, I had about 30 pregnancy tests per month, but now it is double. So, it shows that now more women want to put distance between births.* Female customers attested to the change in behaviour regarding birth control and birth spacing. For instance, one customer said, *In the previous time, every family gave birth every year, but now they gave birth every three to four years.* Another customer concurred, *Yes, at the present time, the families want to have birth every three or four years.*

Respondents not only contributed the change in behaviour to family planning, but they also explained that the implementation of family planning methods has impacted additional social phenomena such as the size of the family and family dynamics. Thus, the health education provided by the health clinic staff has resulted in numerous economic and social impacts that were explained in previous sections (e.g. increased disposable income, greater ability to finance education for children, a more manageable household, greater educational interaction with children, more active social life). For instance, a health shura member described, *The family planning has a good impact on family. In the past, there was no control [of] repeated birth and a result of that there were lots of children in a family. Mostly there were 10-12 children in a family. But now there many ways to control the birth like using condom, tablets and others.* In addition, as mentioned earlier, one of the customers stated, *The family planning programme has really good impact because under this programme the families know how to control the births. As in the past, most families wanted to have between 8-9 children, but it is [now] reduced.*

Finally, in addition to birth control and distance, respondents communicated several other social impacts that have resulted from the health education. The additional social impacts are related to antenatal care and include phenomena such as improved maternal nutrition and vaccinations. For instance, a medical staff member explained, *Family planning had a very good impact on many areas. For example, in the past, mothers didn't take vaccine so rate of mortality was high, and also because of repeatedly birth, mother didn't have chance to make her body stronger for next birth by having good food. Also, people didn't know about the healthy foods, but now most of*

them have been told about what are the healthy food so they eat vegetable beside their daily food.

4.4.2.2 Antenatal Care

Before the health clinic was established, antenatal care was not available to women living in the villages surrounding Tangi Saidan. As a result, women did not know how to properly take care of themselves during pregnancy. For instance, women did not normally observe healthy nutritional habits, limit intensive labour activities, receive appropriate vaccinations or know how to handle potential problems during pregnancy. However, behaviours began to change as the clinic staff provided health education regarding antenatal care. In addition, women are now aware that they should typically visit the midwife at least four times before giving birth, and they know how to identify when it is necessary to visit the clinic in case of complications during pregnancy.

One of the medical staff members illustrated how the situation has changed, *In the past, they [pregnant women] didn't take care of themselves, but now they know how to take care of themselves properly and they surely do take care of themselves. For instance, we advised them what they should eat and what they shouldn't. And they must not lift heavy things, or in case they have bleeding... [or] stomachache they are to come to clinic to see midwife. Beside these, for a normal procedure a pregnant woman is to visit her midwife four times during pregnancy period.*

Respondents identified two cultural traditions concerning nutrition that have negatively impacted maternal health in the villages surrounding Tangi Saidan. First, due to a general lack of knowledge regarding proper nutrition, pregnant women frequently ate traditional food believed to be healthy for expectant mothers. For instance, several of these meals included letti, porridge and alwaa. Letti is a food composed of flour, oil, onion and sugar (or brown sugar), and porridge is a meal made with noodles and is basically composed of water, flour and oil. Alwaa is a dessert made with wheat or corn flour, sugar and oil. Thus, these traditional meals were largely composed of flour, oil and sugar and lacked important protein, vitamins and minerals necessary for maternal nutrition. One of the members of the medical staff explained this tradition, *For example, in the past, mothers ate only noodle and porridge. And for a very long [time] after they have baby [and] for a long time after their delivery, they didn't eat most of good foods like potato, bean, vegetable and some fruits. But now they eat them.*

Second, a few respondents discussed the cultural tradition of generous hospitality toward guests. They explained that men (and guests) customarily took precedence over women in the household when eating meals. As a result, women (even when pregnant) often ate what was leftover. However, as the medical staff has emphasised the importance of proper maternal nutrition, the practise has begun to change. For instance, a medical staff member described, *Because of some cultural issues there were difference between men and women's food quality. For example, when a guest came to a family and the family had a chicken for the guest, then guest and men of the family could eat that, not the women because the chicken was not enough for all of them. But now it is not like that.* Thus, families now know to ensure pregnant women eat equal portions of the best food served to guests.

Although maternal nutrition was traditionally very poor, respondents communicated that the clinic has had a significant positive impact due to health education provided by the medical staff. For example, one member of the clinic staff said, *Since I am working here, I explain to them [pregnant women] about the advantages of vegetables to eat and dairy milk and its productions [yogurt]. So, they eat them now.* Another medical staff member added, *Also, people didn't know about the healthy foods, but now most of them have been told about what are the healthy food, so they eat vegetable beside their daily food.*

Consequently, pregnant women now have a much better understanding of their nutritional needs. Whereas families previously did not understand the proper nutritional requirements for pregnant women, respondents described that they now know pregnant women need to eat meat, dairy, fruit and vegetables to ensure that protein, vitamins and minerals are an essential part of their diet. For instance, one of the CHWs stated that, *In the previous time, the mother didn't know how to feed themselves and didn't know which food have the most vitamin and other useful minerals... but nowadays the mothers know that how to feed themselves and how to prepare food rich of vitamin and minerals for themselves and now they avoid using spoiled food.*

Customers further attested to the fact that although they previously did not have adequate knowledge regarding maternal nutrition, their understanding has improved due to teaching provided by the clinic staff. For instance, one customer claimed, *In the past time, the mothers didn't know what to eat, but right now all mothers have information about feeding themselves.* Thus, the health education provided by the clinic staff has impacted the nutritional habits of pregnant women because they now understand the difference between healthy and unhealthy foods.

As a result, behaviours have generally changed regarding maternal nutrition. For example, a customer stated that, *The women [now] know what should be eaten during pregnancy*. Another customer added, *The women know what to eat while they are pregnant, as they know that they should use from fruits and other food rich of vitamins and protein during pregnancy*. As a result, respondents described that pregnant women now prefer healthy foods that are rich in vitamins and minerals over the unhealthy traditional foods. For instance, a customer exclaimed, *They [pregnant women] prefer those food which are rich of vitamins like bean, pea and vegetables*.

In addition to inadequate nutrition, pregnant women previously did not exercise caution regarding daily activities such as intensive agricultural work or carrying heavy loads. Women had previously performed all work and household chores throughout their entire pregnancy. However, the health clinic staff has been teaching women that they should avoid intensive physical labour and heavy lifting during the later stages of pregnancy and immediately following birth. For instance, a member of the health clinic staff recounted, *For instance, we advised them what they should eat and what they shouldn't and they must not lift a heavy things*. She further added, *Moreover, the mothers were busy in doing of some jobs like harrowing and other things*. Thus, as a result of the health education provided by the clinic staff, respondents suggested women are now more careful with work during pregnancy. A CHW described, *In the previous time, the women didn't take care as they pick up heavy load while they were pregnant, but at the present time the situation is much better than previous time*.

Finally, women previously did not have a clinic to visit for regular antenatal appointments or in the case of complications during pregnancy, and they did not understand the importance of getting properly vaccinated. However, respondents claimed behaviours have changed as the health staff has emphasised the importance of getting vaccinated, planning at least four antenatal visits to the health clinic before delivery and visiting the clinic in case of any problems during pregnancy. For instance, a member of the health clinic staff explained, *Under our family programme we also provide them some recommendation to pregnant women and let them know how they should take care of themselves when they are pregnant... they should refer to us for check up at least four times before their delivery. Beside that they should come to us in case of suffering from some pains like serious headache [or] bleeding*. A separate clinic staff member added, *Family planning had a very good impact on many areas. For example, in the past, mothers didn't take vaccine so rate of mortality was high....*

One medical staff member identified that a challenge with convincing villagers to change behaviours was they previously did not understand how bacteria or germs are related to sickness and disease. Instead, many villagers traditionally believed evil spirits caused sickness. The medical staff member described, *For instance, if a child dies after one week of birth, then people say, 'Look, [a] ghost [evil spirit] killed his child', and we say 'No, it is not the ghost, but it is the Tetanus that killed the child'. And the Tetanus [vaccine] is for women from the age of 15-45 years old.* However, villagers now understand that germs and bacteria cause disease, and that it is important to get vaccinated to help prevent disease. Another member of the clinic staff explained, *Yes, I do provide teaching for them [patients]. For example, I make them realise that prevention is better than treatment and all vaccinations are example of preventions from some certain diseases. I give them this example that says, 'block the way of water before it reaches [you]'. Prevention [of disease] is the same as this example.*

In summary, due to the health education provided by the clinic staff regarding antenatal care, respondents suggested that women currently understand how to properly take care of themselves during pregnancy. For instance, respondents often discussed that women now generally observe healthier nutritional habits and limit intensive labour activities. They also typically receive recommended vaccinations, visit the midwife several times before delivery and understand the importance of going to the clinic in case of potential complications during pregnancy. As a result, women have been empowered to take better care of themselves during pregnancy. One of the customers summarised this general impact, *In the past time, the women didn't have knowledge how to take care of themselves during pregnancy, but nowadays they know how to take care of themselves.*

4.4.2.3 Birth and Delivery

Birth and delivery represents a final area regarding maternal health that has been impacted by the Tangi Saidan health clinic. This area has been impacted both by the health education provided by the medical staff as well as the presence of a delivery room at the health clinic. Improved birth practises and delivery methods have resulted in both social and economic impact. While economic impact regarding maternal mortality was previously discussed, it is the social phenomena surrounding the overall birth process and traditional delivery methods that resulted in high maternal mortality. Thus, comprehensive social impact regarding birth and delivery is expounded below.

General birth practises and traditional delivery methods were abysmal before the Tangi Saidan health clinic was established. Respondents described several underlying reasons regarding how and why birth and delivery in the Tangi Saidan region was traditionally plagued with complications. For instance, respondents suggested that properly trained medical professionals (e.g. midwives, doctors) were simply not available. Alternatively, instead of trained professionals, there were customarily local women who assisted with deliveries. These women were referred to as local midwives or traditional birth attendants (TBAs). For example, one member of the medical staff explained, *Before this clinic, the local midwife [or] traditional midwife or old women with experience helped pregnant [women] with the delivery.*

The problem was that these local women typically lacked any official medical training. As a result, pregnant women had no access to proper antenatal care or professional assistance during delivery of the baby. Thus, the unavailability of trained medical professionals, along with the widespread lack of knowledge regarding birth and delivery, led to many insalubrious cultural practises. For example, one key informant described, *When the poor people gave birth at home [before the health clinic was established], usually old ladies who are claiming to be enough experienced cut the cord by a dirty knife. Cutting the cord by dirty knife is one factor for tetanus.*

A second key informant further illustrated how these untrained TBAs were known to implement unorthodox (and often unsanitary) practises regarding birth and delivery. He stated, *So, culturally you would have a lot of... traditional birth attendants... these TBAs have done very little actual learning of the craft, this art of delivery. But they have done hundreds of them historically. So, what happens is in one or two cases they [TBAs] have done something kind of strange even like cutting the [umbilical] cord with used knives or used scissors or used blades in most of these cases. So, they are rusty and the possibility of Tetanus, that comes into the picture. The possibility of bacterial or viral infections that become systemic... for the mother and the child. Maternal mortality and infant mortality have... skyrocketed I should say, due to these malpractices.*

Further, in addition to the unavailability of medical professionals and general lack of knowledge concerning birth and delivery, there were previously no local medical facilities. As a result, the majority of all deliveries occurred in the pregnant woman's home, and the conditions were often unsanitary. For example, another unhealthy cultural practise that was previously mentioned concerns the traditional method of delivery performed in the villages surrounding Tangi Saidan. One of the

CHWs described this traditional method, *In the previous time [before the clinic was established], the delivery happened in a dirty place where mothers faced with various problems and were very vulnerable with getting some diseases such as Tetanus and other diseases as they paved the soil under pregnant woman's foot during delivery.*

An informant explained that one reason for this unsanitary practise was that birth was generally considered a dirty process. Therefore, people tended to believe that deliveries should be performed in a dirty place rather than soiling a clean place. Respondents further suggested that these traditional cultural practises were exacerbated by the lack of knowledge concerning necessary vaccinations (e.g. Tetanus) for women and ignorance of the benefits of birth spacing. For example, one of the health shura members stated, *In the past [before the clinic existed], normally women gave delivery at home without the help of a well trained CHW [midwife] ... there was no vaccines, there was no hygiene and there was no distance between birth.*

However, behaviours regarding birth and delivery have begun to change for three principle reasons. First, there is a delivery room at the health clinic where medical professionals (e.g. doctors, midwives) perform deliveries. Second, trained midwives are available to assist with home deliveries. Third, the clinic staff provides health education that covers topics regarding birth and delivery. Whereas pregnant women previously gave birth at home on dirt floors, they now typically give birth in the clinic in a sterile environment with the aid of medical professionals such as a doctors and midwives. Deliveries that do occur in the home are now performed with the aid of a trained midwife who uses more sterile procedures and equipment. As a result, behaviours regarding birth and delivery in the villages have changed significantly since the health clinic was established.

One managerial staff member explained the change in behaviour resulting from the clinic, *Now, approximately all pregnant women have baby at the clinic with the help of midwife. Because birth practises changed compared to the past time, and public awareness for people are higher and for this reason most women even before delivery, they are under the prenatal care here at the clinic by midwife. According to the advice of the midwife, they are seen at specific time.* Although the majority of women now prefer to deliver babies in the health clinic delivery room, the clinic is not open at night. Therefore, some deliveries are performed in homes with the assistance of midwives, and a small percentage of pregnant women may travel to Kabul.

A key informant illustrated this situation, *During the day when the clinic is open, they [pregnant women] come to clinic. At the clinic, there is a very well trained*

midwife with good equipment. So, all deliveries get done easily and safely. And if it [is] during the late afternoon when clinic is not open, the rich family take the patient to Kabul and poor family give birth at home. But there is a well trained CHW [midwife] available at the village to help these ladies who give birth at home. Because the majority of families living in the villages surrounding Tangi Saidan are poor, most pregnant women typically give birth at home with the assistance of a midwife during the night hours when the health clinic is not open.

Furthermore, there are sometimes complicated pregnancies that the health clinic staff may not be equipped to handle. In this situation, the pregnant woman will be referred to Kabul for delivery. A key informant explained, *If it [is] a complicated case, surely they [pregnant women] go to Kabul, but it is normal they stay at the village and give birth by the help of CHW midwives at home. And the number of these normal cases are up to 10 deliveries per month.* However, as previously discussed, seeking medical attention in Kabul can be challenging and expensive for families living in the villages. Thus, timing of the delivery may be critical for the health and safety of the pregnant woman. A member of the health shura described that, *If there is no clinic [in Tangi Saidan], the mother may lose her life along the way to Kabul. So, this is the reason why it [the Tangi Saidan health clinic] is very important... I took my patient to Kabul sometimes ago for delivery, but unfortunately while we arrived to hospital the patient passed away although I spent 7,000 Afs.*

Archival evidence provided by MSDEV (e.g. activity reports) was consistent with what respondents indicated during interviews and focus groups regarding the location where deliveries are currently performed. Although there is no data revealing how many deliveries have been performed in Kabul hospitals, MSDEV activity reports provide a breakdown of how many deliveries were performed at the health clinic and how many were conducted in homes. For instance, out of 88 total deliveries recorded in 2012, over 85% were performed at the health clinic whereas only about 15% were conducted in homes. In 2013, out of 128 documented deliveries, over two-thirds were performed in the health clinic versus only about one-third conducted in homes.

Consequently, respondents often commented how the availability of health education, presence of trained medical professionals and access to a sanitary delivery room have broadly impacted behaviours regarding birth and delivery. For instance, one of the medical staff members explained, *In past when pregnant women had baby, normally they had their babies on the soft soil... But we let them know that soil cause tetanus a type of disease. So, we told them to put plastic on the floor and then have the*

baby on the plastic. The staff member continued, ... now not only there is midwife in clinics but also for most of the time the CHW [midwife] can help with [home] delivery very well. CHWs have a special box with clean materials for delivery. Also, the health worker advise women to wash their hands with soap before to help with delivery. A female customer added, In the past time, mostly women did delivery at home without midwife, but now it is changed and most of the women prefer to do it at hospitals or clinic with presence of midwife and doctors.

In conclusion, a key informant summarised how this social impact regarding birth and delivery has improved the lives of women, *A decade ago these guys [pregnant women] weren't even allowed to meet up with a midwife. So, from a social and cultural perspective this opens up the world to the women who have been ill treated for such a very long time. I mean a lifetime for them, but five years to six years of Taliban rule, and also the veil within the culture. But from a medical perspective it is almost the gateway into great living, especially in a rural area [and] especially [for] women... [It is a] better life and better healthier life when a woman is treated well during her pregnancy and has a good delivery, and has been given good health education for taking care of her infants, son, daughter, child. So, for medical reasons it has a big impact.*

4.4.2.4 Summary

In summary, the health clinic has had a positive social impact upon behaviours of people living in the villages surrounding Tangi Saidan. The first subcategory, maternal health, comprises several concepts including birth control and spacing, antenatal care and birth and delivery. First, birth control and spacing are interrelated and have been impacted by the health education provided by the MSDEV medical staff. This concept reveals how the behaviours of families have changed concerning the frequency and number of births desired. Second, maternal health has been impacted as the clinic staff has educated mothers about nutrition, working during pregnancy and vaccinations. Finally, the concepts birth and delivery comprise various social phenomena that have impacted overall maternal health including greater knowledge of the overall birth process, involvement of trained medical professionals and improved delivery methods.

The positive social impact regarding maternal health has primarily occurred as a result of the teaching the clinic staff provides for women and their families. As described above, maternal health education includes various topics such as birth control

methods, appropriate birth spacing, nutrition, working during pregnancy, required vaccinations and safe delivery methods. Additionally, the impact on maternal health has been magnified because the health clinic has a delivery room where trained medical professionals perform deliveries for pregnant women living in the villages. The delivery room has provided a sterile environment and vastly improved the care pregnant women receive during delivery. Therefore, the social impact regarding maternal health has occurred as a result of a combination of education and services provided by the health clinic.

Finally, the health clinic has impacted behaviours beyond maternal health alone. Thus, the second subcategory regarding “behaviours” is hygiene and first aid. Similar to maternal health, social impact regarding hygiene and first aid has also occurred due to both services delivered at the clinic as well as health education provided by the clinic staff. In general, the clinic staff teaches patients about common hygienic practises as well as proper first aid treatment of wounds. Various hygienic practises taught by the clinic staff include hand washing, water and toilet usage, cleaning vegetables and handling garbage. In addition to educating patients about basic hygiene, the medical staff at the health clinic also provides first aid treatment to patients with lacerations and other topical wounds.

4.4.1 Hygiene and First Aid

The second subcategory includes general hygienic practises taught by the clinic staff as well as the teaching and provision of first aid at the clinic. A table of the various categories of respondents can be found in Appendix 2, and the relative contribution by respondent category for each concept regarding hygiene and first aid is illustrated in the following table.

	Hygiene and First Aid	
	General Hygienic Practises	Treating of Wounds
Categories of Respondents	Executive Staff * Medical Staff Health Shura CHW Customers	* Medical Staff Managerial Staff CHW
	* Indicates if a key informant was involved	

Table 4.10: Relative Contribution by Respondent Category – Hygiene and First Aid (SOURCE: Author)

The purpose of educating families about hygiene is to reduce preventable sicknesses and diseases such as diarrhea and intestinal parasites. Thus, teaching patients about general hygiene is an important element of the overall health education provided by the health clinic staff. The basic hygienic practises that the clinic staff teaches include hand washing, water and toilet usage, cleaning vegetables and handling garbage. In addition to basic hygiene, the health clinic staff also teaches families proper first aid techniques. Teaching about first aid mainly includes education concerning the dressing of wounds. This teaching was necessary because villagers previously practised unsanitary methods before the clinic was established. Thus, general hygienic practises and treating of wounds represent the final two concepts that explain how the health clinic has impacted behaviours of people living in the Tangi Saidan region.

4.4.1.1 General Hygienic Practises

The teaching that the health clinic staff provides concerning general hygienic practises includes hand washing, water usage, toilet usage, cleaning vegetables and handling garbage. The hygiene teaching is relatively simple, but it is very important because families did not understand even the most basic hygienic principles before the health clinic was established. For instance, respondents claimed that families generally had insufficient access to any information regarding hygiene before the health clinic in Tangi Saidan was established. One customer recalled that, *People had very poor information regarding hygiene in the past time [before the health clinic was established]*.

Therefore, hygienic practises were lacking in many areas. For example, many people living in the villages surrounding Tangi Saidan previously did not understand the importance of using safe latrines (e.g. proper distance away from the home or source of drinking water). They further did not realise that washing their hands helps eliminate germs that can make them sick, especially after using the latrine or before handling food. Villagers also didn't know the difference between safe and unsafe sources of drinking water or how to properly prepare impure water so that it is safe for consumption. For example, villagers generally did not comprehend that using the same water as animals, such as from a local stream or river, is unsafe for drinking.

It was also not common practise to designate a centralised location for garbage disposal so families tended to haphazardly litter garbage around their property. Further, because manure is often used to fertilise crops, germs and bacteria are commonly found on fruits and vegetables. However, families typically did not understand the importance

of washing fruits and vegetables before consumption or how to properly wash them. It is due to this general lack of knowledge that the health clinic staff has emphasised the importance of implementing consistent hygienic practises to families living in the villages surrounding the Tangi Saidan health clinic. As a result, many people now are empowered with knowledge about proper hygiene.

One of the customers described this change, *In the previous time, the people didn't have any information regarding hygiene. But nowadays they observe all things what they have learned regarding hygiene.* Thus, whereas there was a general lack of knowledge about hygiene before the health clinic in Tangi Saidan was established, the medical staff now regularly teaches patients and families about implementing regular hygienic practises in several areas. For instance, the clinic staff explains that people should wash their hands with soap after using the latrine and before eating or handling food. An informant recounted that, *Washing hands after toilets wasn't common [before the health clinic was established], but now it is.*

The health clinic staff also emphasises that families need to boil water, mix chlorine with water or access a clean water source (with clean utensils) such as a deep water well in order to ensure that drinking water is safe for consumption. For example, a customer claimed, *They [the health clinic staff] told us to mix chlorine in water, then we can drink it.* In addition, the clinic staff instructs families that they should not openly defecate. Rather, they explain the importance of digging an enclosed latrine that is a sufficient distance away from the home and any water source that is used for consumption. For instance, one of the members of the medical staff cited teaching several of these topic areas, *The CHWs give training [to] the families regarding water usage... toilet usage and washing of hands by soap.*

Due to the potential for the germs and bacteria from feces on fruits and vegetables, the clinic staff further educates families how to clean produce with chlorine or salt. Finally, instead of haphazardly littering garbage around the home, the clinic staff instructs families to create a specific location to dispose of garbage. Consequently, many customers emphasised how much they have learned from the teaching on hygienic practises. For example, one customer declared, *We have received some training regarding hand wash, water usage and cleaning of vegetables.* Another customer added, *They educated us on handling of garbage to put it far from our homes.* Yet, a third customer concurred that, *We learned hand washing, usage of drinking water, garbage handling, how to provide clean water with usage of chlorine, washing of vegetables with salt, and etc. from CHWs and clinic staff.*

Overall, most respondents stressed that the teaching is being adhered to by families served by the health clinic. For instance, a health shura member stated, *It [the teaching] impacted on hygiene very much... people now take the garbage far from the villages. In the past, people directly took the fruits from the tree and ate them, but now nobody eat fruits without washing them and about the vegetable is the same. In the past, people took them from the farm and ate them, but now first they wash the vegetable and then eat them.* Another member of the health shura added, *In the previous time, people didn't observe hygiene, but all people are aware from hygiene and observe it [now] like hand wash, water usage and cleaning of vegetables with salt or chlorine.* However, one CHW did not agree that most people fully adhere to the education provided by the clinic staff. For instance, the CHW argued, *Yes, we do give training on mentioned [hygienic] things, but the problem is that most of people don't observe what we tell them regarding general hygiene.*

Thus, there was some uncertainty concerning the extent to which families actually observe the hygienic teaching. It was therefore necessary to review archival evidence to objectively review which clinic visits were related to poor hygienic practises. Two particular clusters regarding hygiene emerged, and the groups were either directly or indirectly related to poor hygienic practises. First, clinic visits due to diarrhea or gastrointestinal (GI) worms were directly related to hygienic practises such as washing hands or water usage. For instance, diarrhea or GI worms may directly result from drinking contaminated water or fecal-oral contact. Second, clinic visits due to acute respiratory illness (ARI) or urinary tract infection (UTI) are indirectly related to the hygienic practises taught by the health clinic staff. These illnesses are indirectly related because they can be transmitted irrespective of hygiene. For example, germs that cause colds and the flu can be transmitted through direct contact or airborne particles so hygiene can only partly reduce the likelihood of contracting these illnesses.

MSDEV activity reports revealed that direct hygiene-related illnesses (e.g. diarrhea and GI worms) accounted for an average of 15% of all clinic visits in 2012. Further, the percentage of total clinic visits represented by these directly-related illnesses ranged from approximately 8% in the months of February and December to over 23% in June that same year. In 2013, the direct hygiene-related illnesses accounted for an average of 16.8% of total clinic visits. The percentage of total clinic visits represented by these same illnesses ranged from approximately 8% in January to over 25% in June in 2013.

The activity reports further revealed that indirect hygiene-related illnesses (e.g. ARI and UTI) accounted for an average of 41.6% of all clinic visits in 2012. The percentage of total clinic visits represented by these illnesses ranged from roughly 34% in July to almost 47% in February of the same year. In 2013, the indirect hygiene-related illnesses accounted for an average of 46.5% of total clinic visits, and the percentage of total clinic visits represented by these illnesses ranged from approximately 35% in November to over 55% in the months of May and June.

If the direct and indirect hygiene-related illnesses are combined, they represent a significant proportion of all clinic visits. For example, over half of all clinic visits were due to either direct or indirect hygiene-related illnesses in 2012 almost two-thirds of all visits were related to the combined illnesses in 2013. One of the MSDEV executive staff members suggested there may be a disconnect between what is taught and what is actually observed regarding hygiene. For instance, he commented, *But I guess if you looked to see how many people are coming in and being treated for water borne illnesses, it's a pretty good indication that the message is not getting out about treating the water.* Thus, it appears that although the hygienic teaching has impacted behaviours to a certain extent, there may be some underlying weaknesses regarding this area of social impact.

During the field research, three potential causes emerged that may partially explain weaknesses regarding this area of behavioural impact. First, the health education provided by the health clinic staff is relatively informal. There are no formal classes that teach the entire range of hygienic practises. Rather, patients are taught as they visit the health clinic, and CHWs occasionally provide training in homes. For instance, an informant described that, *Clinic provides training for CHWs and CHWs share their knowledge regarding health to villagers. Thus, CHWs have posters putting on the walls [of the health clinic] illustrating hygiene and etc.* A CHW further explained, *We go to door to door and train the families and sometimes we preach them in some parties when we are invited.* One of the customers claimed that, *They [CHWs] conducted training door to door and sometimes they gather women in house and conduct their training.*

Therefore, it is plausible that the informality and infrequency of the health education regarding hygienic practises may partly limit its effectiveness. Second, as mentioned above, understanding of basic hygiene was non-existent before the health clinic was established. Because hygienic practises were previously so poor, it is likely that villagers do actually believe they're observing proper hygiene. Their current

hygienic practises (although significantly improved) may simply not be strict enough to adequately prevent the abovementioned hygiene-related illnesses. For instance, one of the executive staff member suggested, *They [villagers] say they are, and they may feel they are [following proper hygienic practises], but I doubt if we are really seeing behavioural change on a family level.*

Finally, it is possible that respondents were intentionally misleading in their responses regarding hygiene. However, responses from the same research study participants triangulated (e.g. through archival evidence, documentation, direct observations, interviews and focus groups) strongly across the other areas of economic and social impact. Thus, although it is a possibility, the broader case study evidence does not indicate that the participants would intentionally provide misleading responses regarding hygiene. It is therefore probable that the teaching methods and subjective beliefs concerning hygienic practises explain the limited effectiveness of the health education in this area. As a result, hygienic practises represent an important area for improving social impact.

4.4.1.2 Treating of Wounds

In addition to basic hygiene, the health clinic staff also educates families about first aid techniques. Teaching families about first aid principally relates to the treating of wounds. Further, the medical staff at the health clinic provides first aid treatment for patients with lacerations and other topical wounds. As a result, health education and curative care services have had a combined impact on the behaviours of families regarding first aid. The health education and curative care services are both necessary because the traditional first aid methods previously practised by villagers were unsanitary, and they lacked sterile equipment and standard medical facilities (for severe cases) required for the provision of effective first aid treatment. Thus, the treating of wounds represents the final concept that explains how the health clinic has impacted behaviours of people living in the Tangi Saidan region.

Many respondents discussed the traditional approach to treating wounds, which included using tobacco (typically referred to as snuff), soil or salt to treat wounds. A key informant illustrated this traditional practise, *For example, in the past when people got wound on his body parts, they used to put tobacco powder and soil on the wound to treat it.* One manager indicated that this practise was primarily due to a lack of knowledge regarding proper first aid treatment. He described that, *... sometimes they [villagers] put snuff over the place that they were injured. But the first [previous] time*

they did not know there were special medications that they now use to treat [the wounds].

Further, individuals often used dirty bandages such as cloth or torn pieces of clothing as bandages, and there was a general lack of concern regarding whether the bandage was sanitary or not. For instance, one of the managers claimed, *They used cotton and fabrics that were for clothing. For example, they made bandages from pieces of scarf and other things like that.* The manager continued, *They didn't care if those fabrics were clean or no.* One of the CHWs added, *They usually use bandage for treatment of wounds, although they used [to use] unclean things for dressing of the wounds [before the health clinic was established].*

Individuals that have been predominantly susceptible to lacerations and topical wounds are men working hard labour such as miners cutting stone for construction or agricultural workers. For instance, respondents described how the miners use very basic equipment for breaking apart stone, so they are particularly vulnerable to injury. One member of the medical staff stated, *They [villagers] work at mine for stone to provide constructions materials so a lot of time their arms, legs and head are broken.* A CHW added, *Dressing of wounds are very important service in our area... people are stone breaker, and during the work sometimes they got wound. So, dressing [of wounds] is very important to me.*

The men working hard labour typically treated wounds themselves in the only way they knew how, and did not visit medical facilities in Kabul unless they were seriously wounded. Thus, injuries could cause severe problems (e.g. excessive bleeding, infection) as a result of the traditionally unsanitary and ineffective methods of treating wounds. However, villagers with more serious injuries can now refer directly to the health clinic in Tangi Saidan. For instance, a member of the medical staff described that, *... people are dealing with cutting of stones and carry it for construction work. And during work, [if] they face with wounding, then they can refer to this clinic. And the clinic medical staff dress up their wounds and save their life.*

Consequently, behaviours have changed dramatically as a result of the first aid training and curative services provided by the Tangi Saidan health clinic staff. For example, villagers now understand that the traditional first aid practises were harmful. An informant exclaimed, *... since they [villagers] received training, they know it is not good to use tobacco. There is standard medication available for [treating] that [wound] at clinic.* One of the CHWs added, *In the previous time, people used the local, traditional treatment. As they [used to] pour soil, snuff and salt over wounds and [did*

not know] this might cause bad effect. But now the people realise how to dress up the wounds. Thus, villagers now understand standard first aid procedures for treating wounds such as relying upon topical medications instead of soil or snuff and ensuring bandages are sanitary. For instance, another CHW pointed out that, At the present time, most of the people know to use from proper medications in treating their wounds like gauze bandage and other medication.

In addition to increased knowledge of individual treatment of wounds, the medical staff has encouraged villagers to seek care at the health clinic for dressing wounds. For example, one of the medical staff members suggested, *In past when people got injured, they put soil on the wound to stop bleeding or sometime they put tobacco power [on the wound]. But now [we] let them know that soil cause diseases, [and they should] go to the clinic and have some good medical staff for dressing [the wound].* Another medical staff member added, *In the past, people used to dress the wounds with tobacco powder, soil and other stuff. But now people come to clinic even for a small wound to dress properly at the clinic.* Therefore, both first aid training and treatment of wounds at the health clinic have contributed significantly to changing the behaviours of people living in the villages surrounding Tangi Saidan.

4.4.1.3 Summary

In summary, the second subcategory includes two concepts – general hygienic practises and treating of wounds. These concepts include the basic hygienic practises taught by the clinic staff as well as the training and provision of first aid at the clinic. As mentioned earlier, the basic hygienic practises that the clinic staff teaches include hand washing, water and toilet usage, cleaning vegetables and handling garbage. Teaching patients about general hygiene is an important element of the overall health education provided by the health clinic staff, and the purpose of educating families about hygiene is to reduce preventable sicknesses and diseases such as diarrhea and intestinal parasites.

In addition to basic hygiene, the health clinic staff provides training for families regarding modern first aid techniques. The first aid training primarily includes education concerning the dressing of wounds. This education was necessary because villagers previously practised unsanitary first aid methods before the clinic was established such as treating wounds with tobacco or soil and using unclean bandages. The clinic further provides curative care services that include the treatment of wounds. As a result, injured villagers can now refer directly to the health clinic to receive immediate medical

attention, especially in the case of serious wounds or lacerations. Thus, general hygienic practises and treating of wounds comprise the final concepts that explain how and why the health clinic has impacted behaviours of people living in the Tangi Saidan region.

4.5 SUMMARISING SOCIO-ECONOMIC IMPACT

During the research study, the theory that emerged from the raw data is characterised by the categories, subcategories and concepts expounded throughout this chapter. For instance, the main chapter headings – “lower health care costs”, “relationships” and “behaviours” – represent the categories that emerged during grounded theory analysis. Each of the categories is separated into two subcategories. The first category, “lower health care costs”, comprises the subcategories the clinic visit and health education; the second category, “relationships”, is composed of the subcategories interethnic relationships and family relationships; and the third category, “behaviours”, includes the subcategories maternal health and hygiene and first aid. The categories, subcategories and concepts are summarised in the following table.

Categories	Subcategories	Concepts
Lower Health Care Costs	The Clinic Visit	Transportation Lost Wages Accommodation Gifts (Nazrana)
	Health Education	Breastfeeding Maternal Mortality Family Size
Relationships	Interethnic Relationships	The Second Public Meeting Place The Role of Women Impact of the Shura
	Family Relationships	Family Dynamics Independence of Women
Behaviours	Maternal Health	Birth Control and Spacing Antenatal Care Birth and Delivery
	Hygiene and First Aid	General Hygienic Practises Treating of Wounds

Table 4.11: Summary of Categories, Subcategories and Concepts (SOURCE: Author)

The category “lower health care costs” represents economic impact of the Tangi Saidan health clinic, and the categories “relationships” and “behaviours” characterise social impact of the clinic. Thus, overall impact is integrated into one central category – socio-economic impact. The central category embodies all action and interaction regarding the research study and integrates the three main categories to comprehensively capture the entire story. The central category also succinctly relates

back to the research question, aim and objectives, which includes understanding and improving economic and social impact. It is therefore important to comprehensively review and assess all of the economic and social impacts in order to holistically understand and improve impact. In fact, London (2009b) suggests that a venture's impacts should be evaluated along two dimensions – magnitude and likelihood.

It is important to include an evaluation of magnitude and likelihood in order to determine the most critical factors concerning a venture's impact and where to focus the attention of managers. For purposes of the current research study, the terms magnitude and likelihood are defined to reduce ambiguity. First, magnitude refers to the relative importance of the impacts discovered in the research study. Second, likelihood is defined as the frequency at which impacts discovered in the study occur. London (2009b) further emphasises the value of evaluating the various impacts discovered during an assessment.

For instance, London (2009b; pg. 109) states, *Once the assessment team has a detailed understanding of all the venture's effects, it needs to evaluate each one along two dimensions: its expected magnitude, and the relative likelihood that it will occur. High-magnitude and high-likelihood outcomes should clearly be considered the most important factors in measuring the venture's performance, while low-magnitude and low-likelihood outcomes deserve the least amount of management's attention.* He further notes that it is imperative to consider the unique context facing the people served by the organisation when deciding which impacts should receive the greatest attention. In other words, organisations should focus resources on the greatest overall impacts that help the poor and priorities should be set with feedback and input from key stakeholders.

In the absence of an explicit two-researcher reliability procedure during the content analysis of the original data, the following assessment of each impact upon the poor (which explains the relative position of each impact within the space of Figure 4.1 below) has been justified by reference to triangulation of data (e.g. documentation, archival evidence, observations, interviews and focus groups). Where interviews and focus groups were used to triangulate data, specific categories of respondents are referenced in the following assessment (e.g. interviews with medical staff or focus groups with CHWs). The categories of respondents used to triangulate each impact have been previously illustrated in tables 4.3, 4.4, 4.6, 4.7, 4.9 and 4.10 found throughout the Results chapter, and there is a comprehensive list of all respondent categories in Appendix 2.

Consequently, the following assessment addresses understanding and improving holistic impact that was discovered during the case study research and analysed using the grounded theory approach. The impacts are represented by the various concepts that have been illustrated throughout the Results chapter, and they are categorised based upon their respective magnitude and likelihood. Assessment of economic impacts includes the concepts transportation, lost wages, accommodation, gifts, breastfeeding, maternal mortality and family size. The evaluation of social impacts involves the concepts the second public meeting place, the role of women, impact of the shura, family dynamics, independence of women, birth control and spacing, antenatal care, birth and delivery, general hygienic practises and treating of wounds. Evaluation of each of the impacts is supported by triangulation of data during the research study through multiple sources of evidence, which is described below.

The greatest overall socio-economic impacts pertain to women, and these phenomena represent high-magnitude/high-likelihood impacts. In particular, the health clinic has had the most significant combined impact upon social phenomena relating to the concepts the role of women, the second meeting place and the independence of women. The role of women was triangulated through interviews with medical staff and managerial staff as well as focus groups with the health shura and CHWs. The second meeting place was triangulated through interviews with medical staff and managerial staff as well as focus groups with the health shura, CHWs and customers. The independence of women was triangulated through documentation, observations, interviews with medical staff and managerial staff and focus groups with the health shura, CHWs and customers. In fact, MSDEV executives expressed that they were relatively unaware of much of the social dynamics regarding women and subsequently learned the most from the research study regarding the broad social impact upon women.

In addition to the social impact upon women, the health clinic has also impacted interethnic relationships through the health shura. Impact of the shura was triangulated through documentation, interviews with executive staff, medical staff and past medical staff as well as a focus group with the health shura. Further, transportation and lost wages represent the two greatest economic impacts regarding the health clinic because families would incur substantial costs every year if travel to Kabul was required to seek medical attention for common clinic visits. Transportation was triangulated through documentation, observations, interviews with medical staff and past medical staff and focus groups with the health shura, CHWs and customers. One final high-

magnitude/high-likelihood economic impact is breastfeeding due to the financial and health ramifications (e.g. cost savings on formula, health of the child) that have resulted. Breastfeeding was triangulated through documentation, interviews with the medical staff and focus groups with CHWs and customers.

Family size, birth control and spacing and family dynamics represent low-magnitude/high-likelihood socio-economic impacts. Family size was triangulated by interviews with medical staff and managerial staff as well as focus groups with the health shura and customers. Birth control and spacing was triangulated by interviews with medical staff and focus groups with the health shura, CHWs and customers. Family dynamics was triangulated by interviews with medical staff and focus groups with the health shura, CHWs and customers. These impacts are not as great in magnitude compared to the role of women or impact of the shura (e.g. impact on interethnic relationships), but the impacts have a high-likelihood of occurring due to the health clinic. For instance, as the health clinic has provided education on family planning, this has resulted in several socio-economic impacts such as the increasing use of birth control and adequate birth spacing, decreasing family size and changing family dynamics. Consequently, many families now perceive birth control and spacing as a common means to improve maternal health and ability to breastfeed, increase household savings and promote a more satisfactory lifestyle.

The high-magnitude/low-likelihood socio-economic impacts include maternal mortality, birth and delivery, antenatal care and accommodation. Maternal mortality was triangulated through documentation, archival evidence, interviews with medical staff and focus groups with the health shura and CHWs. Birth and delivery was triangulated by archival evidence, interviews with executive staff, medical staff and managerial staff and focus groups with the health shura and CHWs. Antenatal care was triangulated by interviews with medical staff as well as focus groups with CHWs and Customers. Accommodation was triangulated through documentation, interviews with medical staff and focus groups with the health shura and customers.

Although relatively infrequent, the economic impact upon maternal mortality is substantial because the death of a mother normally places the family under significant financial stress. Similarly, birth and delivery and antenatal care pertain only to pregnant women, so they occur less frequently compared to total overall clinic visits, but the impact upon maternal health is paramount, so the subsequent impact that does occur is high-magnitude. Further, accommodation costs are high-magnitude because they could represent a significant expense if families were required to seek medical attention in

Kabul. However, most patients typically could travel to Kabul and back in a single day, which would reduce the likelihood of significant accommodation expenses actually being incurred.

Finally, the low-magnitude/low-likelihood socio-economic impacts include the treating of wounds, gifts (nazrana) and general hygienic practises. Treating of wounds was triangulated by archival evidence, interviews with medical staff and managerial staff as well as focus groups with CHWs. Gifts (nazrana) was triangulated through documentation, interviews with medical staff and focus groups with the health shura, CHWs and customers. General hygienic practises was triangulated by interviews with executive staff and medical staff and focus groups with the health shura, CHWs and customers.

Compared to other socio-economic impacts that have resulted from the health clinic such as the role of women and maternal mortality, treating of wounds has not produced as significant of an overall impact regarding magnitude or likelihood. The consequences of this impact are typically not (but sometimes could be) as serious, and the treating of wounds occurs less frequently compared to the other impacts. In addition, gifts (nazrana) depend upon the various medical staff members in Kabul that may demand them, and the majority of families living in the Tangi Saidan region are poor. As a result, the gifts (nazrana) that would be expected of them in Kabul medical facilities are somewhat limited, and the economic impact is relatively low in magnitude and likelihood. Lastly, general hygienic practises represents the final low-magnitude/low-likelihood impact due to the relatively high number of direct and indirect hygiene-related clinic visits.

The following figure illustrates the socio-economic impacts according to magnitude and likelihood of impact as described above. The upper right hand quadrant represents the high-magnitude/high-likelihood impacts, which are the most significant impacts that have resulted from the Tangi Saidan health clinic. The upper left quadrant includes high-magnitude/low-likelihood impacts, and the lower right quadrant comprises low-magnitude/high-likelihood impacts. Thus, the top left quadrant and bottom right quadrant represent moderate impacts overall. Finally, the lower left quadrant represents the low-magnitude/low-likelihood impacts, which are the weakest impacts resulting from the health clinic.

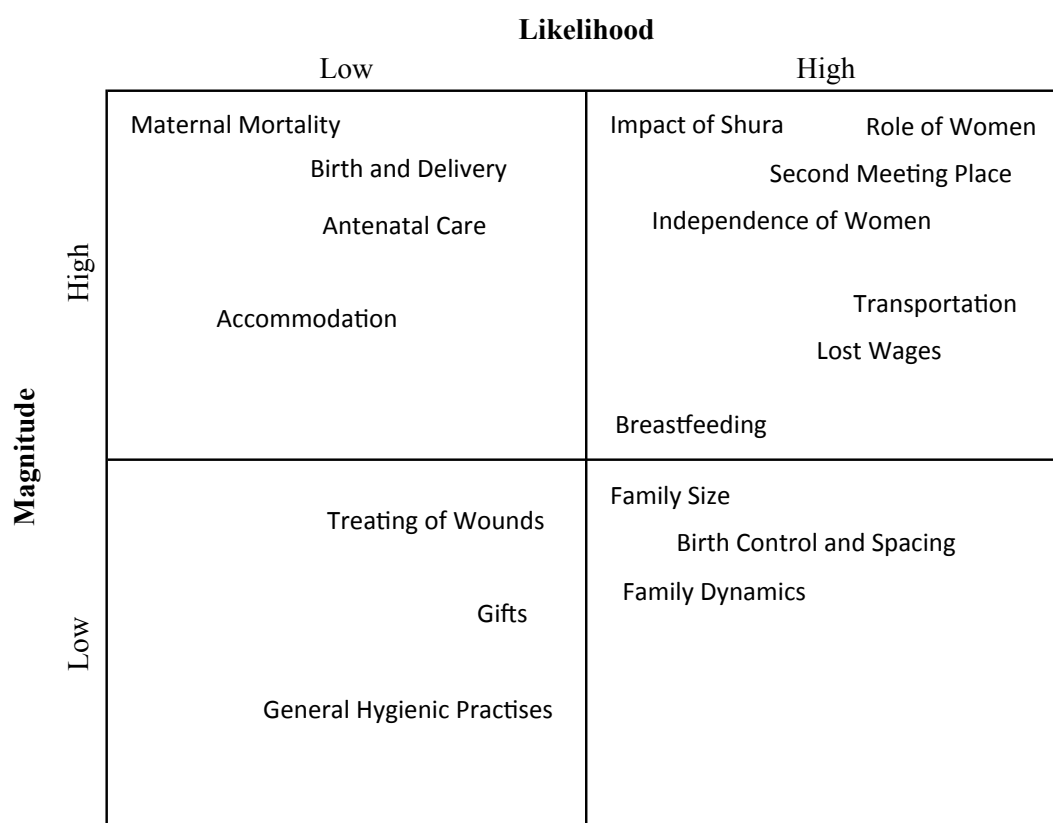


Figure 4.1: Magnitude/Likelihood of Socio-Economic Impacts (SOURCE: Author)

It is important to view the combined socio-economic impacts in the four-quadrant chart to get a comprehensive view of all impacts, or in other words, understand the entire story. This information provides a holistic understanding of the impact of the Tangi Saidan health clinic and identifies priorities for improving impact. As London (2009b) suggests, managers should typically focus on the greatest magnitude impacts that are the most likely to occur so that resources can be allocated toward improving the greatest overall impacts. However, there may be some weaker impacts that are necessary to improve in order to increase the overall impact of the health clinic.

For example, it was previously mentioned that the MSDEV executive team was not fully aware of the significant social impact the health clinic has had upon women (e.g. independence, public meeting place). However, the enhanced knowledge resulting from the research can now provide focus for decision makers regarding improving social impact upon women. Further, the qualitative data suggests that instances of breastfeeding have increased, which has resulted in an important financial impact for families. With this knowledge, decision makers can seek to further improve breastfeeding practises. Finally, general hygienic practises was the weakest area of impact measured during the research study but has significant upside potential to improve the health of families served by the clinic.

In summary, developing the central category was essential for developing a baseline understanding of economic and social impact of the Tangi Saidan health clinic and determining how to improve impact. The central category encompasses all categories, subcategories and concepts developed during grounded theory analysis and integrates the data into a single, comprehensive category. This was an important element of reviewing and assessing all economic and social impacts in order to holistically understand and improve impact and evaluate impacts across the dimensions of magnitude and likelihood. Although the greatest emphasis for improving impact should be placed upon the high-magnitude/high-likelihood impacts (e.g. role of women, impact of shura), there are weaker impacts that may be improved as well such as general hygienic practises. Thus, this comprehensive integration of data was crucial because understanding and improving economic and social impact are central to the research question, aim and objectives.

CHAPTER: 5 CONCLUSION

5.1 OVERVIEW OF GENERALISATION

As discussed above, the Results chapter is designed to achieve a dual purpose. First, the chapter is designed to address the research question, aim and objectives and test, elaborate and extend the existing theory. For instance, the research question broadly includes economic and social impact. These themes are similarly reflected within the structure of the chapter headings because they were the general themes provided by the BoP Impact Assessment Framework. Second, the Results chapter headings and subheadings parallel the categories, subcategories and concepts (theory) that emerged during grounded theory analysis. For example, the category “lower health care costs” represents economic impact while the categories “relationships” and “behaviours” characterise social impact. The Conclusion chapter therefore draws conclusions about these results for the purpose of generalisation.

As previously mentioned, generalisation is not attempted through statistical generalisation because the case study is not a sampling unit. Rather, generalisation from the case study results is achieved through analytical generalisation. This type of generalisation relies upon an existing theoretical framework with which to compare the empirical results (e.g. the inductive theory generated by the raw data) of the case study. Therefore, as recommended by Yin (2009), the research study generalises the results, or theory, developed through case study research to the broader theory (BoP Impact Assessment Framework).

Consequently, the ultimate purpose of the Conclusion chapter is to generalise the results, or theory, developed from the research study against the BoP Impact Assessment Framework. To accomplish this, the actual categories from the framework are compared against the categories, subcategories and concepts (theory) that were inductively generated from the research study. For example, the existing categories on the BoP Impact Assessment Framework include “potential changes in economics”, “potential changes in capabilities” and “potential changes in relationships”. Alternatively, the categories inductively generated during the research study include “lower health care costs”, “relationships”, and “behaviours”. Thus, to achieve analytical generalisation of results, comparisons are made between the pre-existing categories on the BoP Impact Assessment Framework and the categories that were inductively developed during grounded theory analysis.

5.1.1 BoP Impact Assessment Framework – Existing Theory

In order to compare the categories on the BoP Impact Assessment Framework with the categories that were inductively developed during the research study, it is necessary to first review the categories of the existing framework. As previously mentioned, the first category of the BoP Impact Assessment Framework, “potential changes in economics”, contains a variety of potential economic impacts such as income or revenue, income stability and savings. Other impacts may include changes to assets, debt or even productivity. In addition, there may be a combination of several different impacts that are positive or negative such as increased income and savings but decreased income stability (Esper et al., 2014).

Further, the second category on the BoP Impact Assessment Framework is “potential changes in capabilities”. This category is much broader and relatively more abstract compared to the first category. Further, the second category pertains to social impact of a BoP venture whereas the first category clearly relates to economic impact. For instance, social impacts relating to capabilities include knowledge, skills and self-confidence. However, in addition to direct effects from increased knowledge and skills, social impacts relating to capabilities may broadly range from changes in physical and psychological health to personal dignity and individual or collective aspirations. Similar to the first category, impacts may be both positive and negative (Esper et al., 2014).

Finally, the third category on the BoP Impact Assessment Framework is “potential changes in relationships”. Like the second category, this last category pertains to social impact of a BoP venture. Thus, two of the three categories are derived from social impact while only a single category represents economic impact. The third category is also a very wide-ranging category (like the second category). For instance, “potential changes in relationships” can include direct impacts to social support, social networks and relationships with spouses and other family members. However, it can further include more subtle impacts such as roles or status within the family and society as well as values and beliefs about society. Changes in relationships may include positive or negative impacts, which is similar to the other categories (Esper et al., 2014).

The following table summarises all potential changes within each category (e.g. economics, capabilities and relationships) of the BoP Impact Assessment Framework, and it is within this comprehensive framework that general economic and social impacts are systematically defined.

BoP Impact Assessment Framework Category Composition

Potential Changes in Economics	Potential Changes in Capabilities	Potential Changes in Relationships
+/- Income/Revenue	+/- Physical health	+/- Social support
+/- Income stability	+/- Psychological health	+/- Social networks
+/- Savings/Assets	+/- Knowledge	+/- Relationship with spouse
+/- Debt	+/- Skills	+/- Relationship with family members
+/- Economic risk	+/- Self-confidence	+/- Support to family members
+/- Cost to engage venture	+/- Self-efficacy	+/- Interactions with family members
+/- Productivity	+/- Self-worth	+/- Roles/status
+/- Expenditure	+/- Empowerment	+/- Access to formal institutions
	+/- Contentment	+/- Values and beliefs about society
	+/- Dignity	+/- Local environment
	+/- Aspirations	+/- Ecosystem outcomes
		+/- Home environment

Table 5.1: BoP Impact Assessment Framework Category Composition (SOURCE: Esper et al., 2014)

Reviewing this comprehensive list of potential impacts regarding the BoP Impact Assessment Framework is essential for subsequently making comparisons, which are necessary for analytical generalisation. Thus, the following section describes the categories that were inductively developed during the research study, and the final section compares the BoP Impact Assessment Framework categories outlined in this section with the categories inductively developed during the research study in order to generalise results.

5.1.2 Case Study Method/Grounded Theory Approach – Inductive Theory

The categories that were inductively developed during the case study research (using grounded theory analysis) are “lower health care costs”, “relationships” and “behaviours”. These three categories emerged from the data by using only general themes (e.g. economic and social impact) provided by the BoP Impact Assessment Framework instead of the exact categories. This approach was important to allow the specific categories discovered during the research study to naturally emerge from the data. For instance, Strauss and Corbin (1998) indicate that general categories (from an existing framework) may inform initial data collection in grounded theory, but data is collected inductively and final categories emerge from the raw data.

Thus, the first category, “lower health care costs”, emerged during the research study and describes the economic impact of the health clinic. As previously discussed, “lower health care costs” is further broken down into two subcategories – the clinic visit and health education. The concepts that comprise the clinic visit include transportation, lost wages, accommodation and gifts (nazrana). In addition, the concepts included within health education are breastfeeding, maternal mortality and family size. All of the concepts that were generated within the first category pertain to the theme economic impact, which was provided by the BoP Impact Assessment Framework.

The second category that emerged during the research study is “relationships”. This category is one of two categories that represent social impact of the health clinic. As mentioned earlier, the category “relationships” includes the subcategories interethnic relationships and family relationships. Interethnic relationships is further broken down into the concepts the second meeting place, the role of women and the impact of the shura. Family relationships is comprised of the concepts family dynamics and independence of women. Thus, the category “relationships” describes impact within the family and in society as a whole in the Tangi Saidan region.

The third category that was inductively developed during the research study is “behaviours”. In addition to “relationships”, this final category also represents social impact of the health clinic. The category “behaviours” is comprised of two subcategories – maternal health and hygiene and first aid. Maternal health includes the concepts birth control and spacing, antenatal care and birth and delivery. Hygiene and first aid is comprised of the concepts general hygienic practises and treating of wounds. All concepts that were generated within the second and third categories (e.g. “relationships” and “behaviours”) relate to the theme social impact provided by the BoP Impact Assessment Framework.

Collectively, the categories, subcategories and concepts represent the theory that was inductively generated during the case study research (using grounded theory analysis). The entire theoretical framework (inductive theory) is outlined in the following table.

Final Theoretical Framework (Inductive Theory)			
	Categories	Subcategories	Concepts
Economic Impact	Lower Health Care Costs	The Clinic Visit	Transportation Lost Wages Accommodation Gifts (Nazrana)
		Health Education	Breastfeeding Maternal Mortality Family Size
Social Impact	Relationships	Interethnic Relationships	The Second Public Meeting Place The Role of Women Impact of the Shura
		Family Relationships	Family Dynamics Independence of Women
	Behaviours	Maternal Health	Birth Control and Spacing Antenatal Care Birth and Delivery
		Hygiene and First Aid	General Hygienic Practises Treating of Wounds

Table 5.2: Final Theoretical Framework – Inductive Theory (SOURCE: Author)

There are two elements to note concerning the table. First, economic impact and social impact are the general themes that were initially provided by the BoP Impact Assessment Framework. As a result, these themes are separated by the larger vertical dotted line on the left side of the table. Second, the categories “relationships” and “behaviours” (along with respective subcategories and concepts) are related to social impact. Therefore, the two respective groups of categories, subcategories and concepts are separated by the smaller horizontal dotted line. Besides those particular elements, the categories, subcategories and concepts read from left to right on the table. Finally, having illustrated the composition of the BoP Impact Assessment Framework categories (existing theory) and final theoretical framework (inductive theory) of the current research study, it is necessary to make comparisons between the two theories to generalise results.

5.2 ANALYTICAL GENERALISATION

As mentioned above, generalisation from the case study results is achieved through analytical generalisation. This type of generalisation relies upon an existing theoretical framework with which to compare the empirical results (inductive theory generated by the raw data) of the case study. In analytical generalisation, the researcher seeks to generalise a particular set of results, or theory, developed through case study research to some broader theory (Yin, 2009). Therefore, the BoP Impact Assessment Framework not only facilitated data collection and theory development, but it is also used here as a theoretical template with which to generalise empirical results (inductive theory) of the case study.

In addition, the themes economic impact and social impact represent the conceptual link between the BoP Impact Assessment Framework and the research study design. Thus, the themes provide a means by which to compare the categories on the BoP Impact Assessment Framework (existing theory) and categories inductively developed during case study research and grounded theory analysis. This link between the existing theory and the inductive theory generated during the research study provides a means for generalising results. The general themes, existing categories from the BoP Impact Assessment Framework and categories inductively generated during the research study are illustrated in the following table.

Study Design Themes	BoP Impact Assessment Framework	Category Comparison	Case Study Method/ Grounded Theory
Economic Impact	Potential Changes in Economics	↔	Lower Health Care Costs
Social Impact	Potential Changes in Relationships	↔	Relationships
	Potential Changes in Capabilities	↔	Behaviours

Table 5.3: Comparison of Existing Theory and Inductive Theory (SOURCE: Author)

Thus, the subsequent analysis compares the categories from the BoP Impact Assessment Framework (existing theory) against the categories inductively generated during the research study (inductive theory) so that the results can be generalised.

As mentioned above, the category “potential changes in economics” comprises various economic impacts including changes to income, revenue, savings, assets, debt and expenditures. Likewise, the primary economic impacts pertaining to “lower health care costs” discovered during the research study such as transportation, lost wages,

accommodation, breastfeeding and family size primarily relate to changes in reduced expenditures, increased income stability, greater savings and lower debt burden. Therefore, the category “potential changes in economics” from the BoP Impact Assessment Framework represents a sufficiently broad category for understanding all economic impact regarding “lower health care costs”. By assessing each economic impact according to magnitude and likelihood, the BoP Impact Assessment Framework further provided a means for identifying how to improve economic impact. As a result, the BoP Impact Assessment Framework proved to be an effective assessment tool regarding understanding and improving economic impact.

The category “potential changes in relationships” includes many social impacts such as social networks, relationship with spouse, relationships with family, roles/status, values and beliefs about society and the local environment. The social impacts relating to the category “relationships” are very similar. For instance, impacts include changing social networks (particularly for women), the changing role of women in society, improved interethnic relationships and changing family dynamics due to smaller family sizes. Thus, the category “potential changes in relationships” from the BoP Impact Assessment Framework represents a precisely descriptive category for understanding all social impact regarding the inductively generated category “relationships”. By assessing the relational impacts according to magnitude and likelihood, the BoP Impact Assessment Framework further provided a means for identifying how to improve social impact. Thus, regarding “relationships”, the BoP Impact Assessment Framework proved to be an effective assessment tool for understanding and improving social impact.

The category “potential changes in capabilities” comprises many social impacts such as knowledge, skills, self-efficacy, physical health, dignity and aspirations. Although the impacts relating to the category “behaviours” are more narrowly focused than those covered by “potential changes in capabilities”, social impacts regarding “behaviours” clearly fit within the BoP Impact Assessment Framework. For example, various impacts concerning “behaviours” include improved maternal health (e.g. antenatal care, birth and delivery), increased knowledge regarding general hygiene and better health outcomes for wounded individuals. As a result, the category “potential changes in capabilities” from the BoP Impact Assessment Framework represents a sufficiently comprehensive category for understanding all social impact regarding the inductively generated category “behaviours”. By assessing the behavioural impacts according to magnitude and likelihood, the BoP Impact Assessment Framework further provided a means for identifying how to improve social impact. Thus, regarding

“behaviours”, the BoP Impact Assessment Framework proved to be an effective assessment tool for understanding and improving social impact.

The BoP Impact Assessment Framework not only facilitated data collection and theory development, but it was also used here as a theoretical template with which to generalise empirical results (inductive theory) of the case study. Further, the themes economic impact and social impact represent the conceptual link between the BoP Impact Assessment Framework and the research study design. As a result, the themes provided a means by which to compare the categories on the BoP Impact Assessment Framework (existing theory) with the categories inductively developed during the research study. In each case where the inductively generated categories were compared against the existing categories from the BoP Impact Assessment Framework, it was discovered that the empirical results (inductive theory) are generalisable against the existing theory. Thus, referring back to the research question, aim and objectives, the conclusion drawn through analytical generalisation reveals that the BoP Impact Assessment Framework is an effective assessment tool for organisations to understand and improve their economic and social impact in the communities they serve.

Generalisation of the abovementioned results generated by the research study has made two important content contributions to the BoP literature regarding academic understanding of private sector developmental interventions – support for the central premise of the BoP concept by demonstrating how a BoP venture has helped the poor and support for the BoP Impact Assessment Framework by successfully testing it in a challenging and unique context. First, generalisation of the study results is critical for the BoP field of literature due to the fact that the central premise of the BoP concept (e.g. mutual value creation) is not well supported in the literature. For instance, as previously mentioned, much of the literature in the BoP field is based upon numerous ventures that have been launched during the last decade, and there are many cases that analyse these BoP ventures and highlight successes and failures. However, results of these various case studies found throughout the literature should be accepted with caution because comprehensive evidence concerning positive poverty alleviation outcomes are lacking. In other words, impact assessment revealing that BoP interventions actually help the poor are nearly absent from the literature (London, 2007 (July), 2009b).

Additionally, the BoP venture successes that are illustrated throughout the literature typically use anecdotes to describe positive impact upon poverty alleviation instead of data produced from rigorous impact assessments. Because the central premise

of the BoP concept is not well supported in the literature, impact assessment is a critical gap in the literature requiring research to empirically demonstrate how BoP ventures are helping the poor (London, 2007 (July), 2009b). Therefore, data that has been generalised in the research study has produced important empirical evidence within the BoP field of literature needed to substantiate venture impact upon poverty alleviation. Consequently, the current research has provided a case study that supports the central premise of the BoP concept (e.g. mutual value creation) by empirically demonstrating how a BoP venture has actually helped the poor.

Second, generalisation of results is significant because they have been generalised against the single framework available in the BoP literature that measures impact of a BoP venture upon poverty-alleviation outcomes – the BoP Impact Assessment Framework (London, 2009b; London and Anupindi, 2010). Therefore, using this important framework, the gap in assessment has been addressed through an empirical research study of a health care venture targeted at the BoP market in Afghanistan. In particular, testing BoP Impact Assessment Framework is valuable regarding the BoP field of literature because the framework has been applied in few contexts. Therefore, the research has addressed the literature gap and generated insights regarding impact of BoP ventures upon poverty alleviation by testing the existing framework in a unique context – the BoP health sector in Afghanistan. Ultimately, the results support the integrity of the framework and reveal how a BoP venture is helping the poor.

In conclusion, because the BoP Impact Assessment Framework was found to be an effective assessment tool for organisations to understand and improve their economic and social impact in the communities they serve, the research study results have contributed empirical evidence that supports the central premise of the BoP concept through revealing how a BoP venture is helping the poor. The empirical evidence includes economic impacts such transportation, lost wages and family size as well as social impacts such as the role of women, impact of the shura and birth control and spacing. In addition, generalisation of results has demonstrated that the BoP Impact Assessment Framework is a rigorous assessment tool by testing the framework in a unique context – the BoP health sector in Afghanistan. Finally, although this research study has primarily made content contributions to the BoP field of literature in the two areas discussed above, there are additional academic and business, or professional, implications that emerged from the research. Therefore, several positive implications resulting from the research study are discussed in depth in the following section.

IMPLICATIONS

The Implications chapter is an important final chapter of the thesis. In this chapter, both academic and business implications are considered. First, academic implications of the research study are explored in four areas – theoretical implications, academic understanding of private sector developmental interventions, limitations and future research. Theoretical implications relate to how the research study addresses the gap in the BoP literature regarding impact assessment, or how BoP ventures are helping the poor. Academic understanding of private sector developmental interventions describes various content contributions made by the empirical research study. However, though the research study addresses a particular gap in the literature and makes several content contributions, there are limitations of the study. Finally, there are various opportunities for future research, which partly result from certain limitations of the study.

Second, business, or professional, implications regarding assessment of private sector developmental interventions in the BoP market are discussed. Business implications are important so that practitioners can learn from the research study. Thus, various professional implications from the study include assessment best practices, socio-cultural considerations, understanding the target market, innovating or developing the business model and communicating with stakeholders such as staff, partners and donors. Best practices regarding assessment of private sector developmental interventions are critical to ensure rigorous procedures are applied during an impact assessment. Socio-cultural considerations are paramount as BoP ventures reach into new, diverse cultures, and impact assessment is vital for developing a deeper understanding of the venture's target market. In addition, learning generated during impact assessment informs ongoing business model development so that appropriate business strategies can be implemented to better serve the target market. As a result, communication with all stakeholders can be improved.

6.1 ACADEMIC IMPLICATIONS

The academic implications of the research study are explored in four areas, which include the theoretical implications of the research, academic understanding of private sector developmental interventions, limitations of the study and possibilities for future research. First, the theoretical implications of the research study relate to the gap in assessment in the BoP literature. As previously discussed, much of the BoP literature is based upon various ventures that have been launched during the last decade. While cases that highlight the successes and failures of BoP ventures abound, results should be accepted with caution because comprehensive evidence concerning positive poverty alleviation outcomes is lacking. In addition, BoP venture successes that are illustrated throughout the literature typically use anecdotes to describe positive impact upon poverty alleviation. Thus, the central premise of the BoP concept is not well supported in the literature, and research regarding impact assessment, or how BoP ventures help the poor, is a critical area in the literature requiring empirical research (London, 2007 (July), 2009b).

Consequently, comprehensive, empirical assessment of BoP venture impact upon poverty alleviation in the literature is virtually non-existent. In other words, evidence that BoP ventures actually help the poor is lacking. This means that while many organisations are launching BoP ventures, there is little empirical evidence in the literature that substantiates their impact upon poverty alleviation. As a result, assessment is a critical gap within the BoP literature that needs further development because the BoP concept cannot be proven without demonstrating that BoP ventures help the poor. Therefore, to address the crucial gap in assessment, the BoP Impact Assessment Framework was tested through an empirical research study of a BoP venture targeted at the BoP market in Afghanistan (London, 2009b; London and Anupindi, 2010).

In order to test the BoP Impact Assessment Framework, the research study was conducted in a unique context – the health care sector in Afghanistan. Thus, the study was designed to test the theoretical framework within this context. For instance, the research paradigm was phenomenological in nature, which followed a qualitative, inductive approach to research. Phenomenology is a more holistic approach than positivism because it is able to provide rich explanation and understanding of multiple complex phenomena, which was important given the context of the research study. Similarly, qualitative research has a greater potential to provide descriptive detail and holistic understanding of phenomena compared to quantitative research. Thus, it takes a

more holistic view of phenomena and is better suited to deal with a higher level of subjectivity (Bryman and Bell, 2011; Creswell, 2009).

The research methodology comprised empirical, field-based research, which are frequently used methodologies throughout the BoP literature (London, 2005, 2009b; London and Hart, 2004; London et al., 2010; Simanis, 2010; Viswanathan et al., 2009). Further, the case study method was chosen because this method effectively addresses *what*, *how* and *why* questions. The case study method is also appropriate when the researcher has little control over events and the research emphasis is on real-life, contemporary phenomena, which was critical during the research study (Yin, 2009). In addition, use of the case study method in the BoP literature is prolific (Anderson and Markides, 2007; London et al., 2010; Prahalad, 2002, 2010; Prahalad and Hammond, 2002; Prahalad and Hart, 2002; Seelos and Mair, 2007; Simanis and Hart, 2006; Wheeler et al., 2005).

As recommended by Yin (2009), triangulation was achieved during the study by relying upon multiple sources of evidence (e.g. documentation, archival evidence, direct observations, interviews and focus groups) within the case study method. Collecting information from multiple sources was aimed at corroborating the same facts or phenomena around converging lines of inquiry. For example, during the research study, data was triangulated when events or facts were supported by more than a single source of evidence. Further, the data from multiple sources of evidence were collected in three stages using theoretical sampling, which guided actual data collection such as the selection of research participants. Theory was developed through theoretical sampling by collecting, coding and analysing data into concepts and categories until theoretical saturation of each category was reached (Bryman and Bell, 2011; Glaser and Strauss, 1967).

The data was subsequently analysed using grounded theory, and results were generalised through analytical generalisation. For instance, grounded theory is derived from data that is systematically collected and analysed through the research process, and grounded theory represents an iterative process because data collection and analysis are carried out concurrently. As a result, grounded theory represents a primarily inductive process in which theory emerges from the raw data. Although grounded theory is a primarily inductive process that allows theory to emerge from the raw data, a research study may begin with an existing theory (e.g. BoP Impact Assessment Framework) if the purpose of the study is to elaborate and extend that theory (Strauss and Corbin, 1998; Yin, 2009). Analytical generalisation was therefore achieved during the research

study by generalising the empirical results, or theory, against the BoP Impact Assessment Framework.

Thus, the categories on the final theoretical framework (inductive theory) that were generated during the research study were ultimately compared against the BoP Impact Assessment Framework. In each case where the inductively generated categories were compared against the existing categories from the BoP Impact Assessment Framework, it was found that the empirical results (inductive theory) were generalisable against the existing theory. Therefore, the research study revealed that BoP Impact Assessment Framework is an effective assessment tool for organisations to understand and improve their economic and social impact in the communities they serve.

Second, the academic understanding of private sector developmental interventions relates to the various content contributions made by the empirical research study. The research study has made several content contributions to the BoP literature including BoP venture impact on the poor, BoP research in Afghanistan and BoP research in the health sector. For instance, content produced from empirical research results supports that private sector developmental interventions can have significant positive impacts upon the poor. From an economic perspective, the empirical study demonstrated (assuming a standard wage of 400 Afs) that the cost savings attributed to an average single clinic visit might equal approximately three days of wages due to the various impacts measured in the study including transportation, lost wages, accommodation and gifts (nazrana). Further, the empirical data revealed that women enjoy greater independence in the Tangi Saidan region compared to other areas of Afghanistan due to the overall high quality of services provided at the clinic and the trust the clinic staff has established with families living in the surrounding villages.

Academic understanding of private sector developmental interventions also includes content contributions relating to BoP research in Afghanistan. For instance, empirical research on the BoP demographic in Afghanistan is virtually absent from the BoP literature. While the research study only focused on a small intervention within the country, some key insights have been generated regarding the cultural and religious context of the BoP demographic in Afghanistan. For instance, any private sector developmental intervention should take tribalism (e.g. Pashtuns, Tajiks, Hazaras) into account. The empirical results revealed that this was critical to the success of the private sector developmental intervention in the research study. Further, the cultural and religious context of the BoP demographic in Afghanistan is also heavily influenced by Islam. Therefore, it was important to understand how the religion impacts cultural

practices in Afghanistan such that only men are allowed to visit mosques, which magnified the social impact of the health clinic (e.g. the second meeting place and the role of women). Consequently, private sector developmental interventions in Afghanistan should pay close attention to how the venture will impact (and be impacted by) the unique cultural and religious context of the BoP demographic.

In addition, academic understanding of private sector developmental interventions includes content contributions relating to BoP research in the health sector in Afghanistan. Little data is available concerning the BoP health sector, and virtually no research has been conducted on the BoP health sector in Afghanistan. However, the empirical research study has revealed that private sector developmental interventions in the Afghanistan health sector might expect broader impact beyond measured health indicators. In fact, some of the greatest impacts discovered during the research study were social impacts to women that had occurred as a result of the private health sector intervention. For example, God-sisters have formed among various tribes and interethnic marriages have taken place because the health sector intervention brought women together in a central public meeting place for the first time resulting in the interaction among women from different tribes. This reveals that private health sector interventions may have a larger social role to play in Afghanistan beyond what can be measured by health statistics alone.

Third, although content contributions relating to academic understanding of private sector developmental interventions are significant, there are limitations regarding the overall generalisation of the research study. Although the existing framework proved to be an effective assessment tool within the unique context of the health care sector in Afghanistan, this does not mean that it will be an effective assessment tool in all other contexts such as different geographic locations or additional sectors. This is a limitation inherent in analytical generalisation because this approach to generalisation does not attempt to generalise quantitative results to a statistical sample. Rather, it is a qualitative approach that generalises theoretical results to an existing theory. Therefore, the generalisability of results is one limitation of the study.

The existence of investigator and courtesy bias represents a second limitation of the research study. Whereas every researcher faces investigator bias, courtesy bias occurs when research participants give misleading favourable responses during interviews, focus groups or surveys. In addition, courtesy bias can be higher when interviews are conducted on-site at medical facilities or when participants include facility personnel (Edward et al., 2011; Glick, 2009; Yin, 2009). It was necessary to be

aware of the potential for bias during the research study for three primary reasons. First, the study design required objective assessment of both positive and negative impacts. Second, although interviews and focus groups did not take place in the health clinic during the research study, they were conducted on secure premises operated by Morning Star Development. Third, health clinic staff participated in interviews and focus groups because they are important stakeholders.

Therefore, as recommended by Yin (2009), several steps were taken to minimise bias. These included being aware of bias, eliminating preconceived notions, using good listening skills, being adaptive and flexible, including a comprehensive case study instrument, creating a database (e.g. field notes, transcriptions, documents), maintaining a chain of evidence (e.g. grounded theory analysis) and relying on multiple sources of evidence. In particular, the purpose of collecting information from multiple sources (e.g. documentation, archival evidence, direct observations, interviews and focus groups) was to corroborate the same facts or phenomena around converging lines of inquiry. This was critical because case study findings and conclusions are more accurate and credible if they are based upon multiple sources of evidence. Thus, the multipronged approach to research study design not only resulted in triangulation of the data, but it also helped overcome problems associated with construct validity and reliability.

A final limitation of the study is that the research study tests only the first component of the existing framework. For instance, the BoP Impact Assessment Framework contains two elements – the Strategic Analysis and the Performance Analysis. The Strategic Analysis, which is the first element of the framework, requires qualitative research and relates to understanding and improving impact. This element is completed prior to (and separately from) the Performance Analysis. The Performance Analysis, on the other hand, is a separate process and involves developing a set of quantitative indicators identified from the Strategic Analysis to track impact over time. Therefore, the research question, aim and objectives were designed to test the Strategic Analysis element of the framework.

This is a limitation because the research study does not test the framework in its entirety. However, to wholly test the framework, it would have required a longitudinal study involving several more years of research. Unfortunately, the time and resources were not available to undertake two to three additional years of research. Because the research study only tested the Strategic Analysis, there was no quantitative element to the research study. Therefore, a final limitation of the study is that the research study is qualitative only. This limitation could have been eliminated by undertaking a mixed

methods study. However, as mentioned above, the Strategic Analysis element of the framework is qualitative while the Performance Analysis element of the framework is quantitative. As a result, integrating quantitative methods into the research study would have required substantially more time and resources.

Finally, (partly due to the limitations of the study) one important opportunity for future research is to test the entire framework. Thus, a future research study could involve the Strategic Analysis and Performance Analysis. By including both elements of the BoP Impact Assessment Framework, the research study would involve qualitative and quantitative methods. However, including both elements of the framework would require a longitudinal study, and a research study of this length and complexity should only be undertaken if the necessary time and resources are available to the researcher. Therefore, although a great benefit of a mixed methods study (including the Strategic Analysis and Performance Analysis) would be testing the framework in its entirety, significant costs would be associated with this research design.

A second opportunity for future research would be testing the BoP Impact Assessment Framework in other contexts. This could include other regions (e.g. Africa or Latin America) or countries as well as other socio-cultural contexts (e.g. various tribal groups within different countries). The framework could also be tested in other sectors such water, energy or housing. In addition, future research studies could test the Strategic Analysis only (which was the approach in the current research study), or mixed methods studies could be developed to test the entire framework including both the Strategic Analysis and Performance Analysis. Testing the framework (incorporating one or both elements) in different contexts is important because the BoP demographic is not a monolith. Rather, this large demographic of approximately four billion people is diverse, and there is significant variability within the broad demographic regarding income levels, literacy, geographic mix, cultural norms and religious differences (Prahalad, 2004).

A final opportunity for future research could be developing entirely new frameworks to assess BoP ventures. Aside from London's (2009b) BoP Impact Assessment Framework, impact assessment is largely absent from the literature. As previously discussed, this framework includes three general categories (e.g. "potential changes in economics", "potential changes in capabilities" and "potential changes in relationships") that broadly encompass general themes regarding economic and social impact. However, it is possible that there could be additional themes or categories that are relevant for impact assessment but are not covered by the BoP Impact Assessment

Framework. Therefore, there may be room for exploratory research to discover new frameworks for assessing BoP venture impact upon poverty alleviation.

6.2 BUSINESS IMPLICATIONS

There are several business, or professional, implications regarding assessment of private sector developmental interventions in the BoP market that emerged from the research study, and these implications pertain to lessons that managers can glean from the study. The professional implications include assessment best practices, socio-cultural considerations, understanding the target market, innovating or developing the business model and communicating with stakeholders such as staff, partners and donors. For instance, learning is generated during impact assessment, and it is crucial to leverage assessment best practices and appropriately consider socio-cultural phenomena regarding BoP venture impact. In addition, learning deepens understanding of the target market and informs ongoing business model development so that appropriate business strategies can be implemented to better serve the target market. Impact assessment also plays a central role regarding internal and external dialogue with stakeholders.

First, the empirical research study revealed several best practices regarding assessment of private sector developmental interventions in the BoP market. Four best practices were identified including building rapport and trust with key informants, collecting data from multiple sources of evidence, using a case study instrument and relying on rigorous data analysis procedures. For instance, one informant was essential to the success of the research study because he provided key insights regarding the overall Afghanistan health sector as well as access to organisational information and resources that facilitated research on the Tangi Saidan health clinic. In addition, two informants were critical to the success of the research study because they initiated access to additional sources of evidence (e.g. interviews, focus groups) during field research and often provided superior insight into phenomena. In other words, they typically knew which respondents might have knowledge of information that was missing or needed during data collection or could provide relevant insights themselves.

Collecting data from multiple sources of evidence was paramount for triangulation of empirical results. The multiple sources of evidence included documentation, archival evidence, observations, interviews and focus groups. During the research study, data was triangulated when facts or phenomena were supported by different or several sources of evidence, and data collection continued until all sources of evidence were exhausted and there was a corroboration of facts or phenomena. In particular, triangulation was essential for understanding certain perceived inconsistencies regarding the concept transportation. For instance, most respondents simply stated that there are no public buses available in Tangi Saidan, and this was

consistent with direct observations. However, a few respondents did mention that buses are sometimes available. Although this initially seemed inconsistent with what other respondents had stated about the availability of public buses, triangulating results (e.g. observations, interviews and focus groups) eventually clarified that there is a bus stop between Tangi Saidan and Kabul but no direct service into Tangi Saidan.

Another best practice regarding assessment of private sector developmental interventions in the BoP market is using a case study instrument (e.g. questionnaire). The case study instrument was the primary data collection tool used in the research study. Using this instrument in the research study was effective because questions were adapted from the literature, contextualised to the local situation in Afghanistan with input from MSDEV executive staff and refined during initial data collection. Questions were also semi-structured to allow flexibility in asking questions. Additionally, rather than having all questions strictly directed at the respondent, the core questions acted as a guide to keep the researcher on track during interviews. This was critical when probing for deeper understanding regarding phenomena or for cross-questioning respondents in order to triangulate data.

A final best practice is leveraging rigorous data analysis procedures. There are several recommended procedures should be used during an impact assessment. Relying upon iterative data collection and analysis, theoretical sampling, theoretical saturation, coding and memos ensured the deluge of data was thoroughly saturated, properly developed and accurately coded. For instance, it was critical to begin data analysis (e.g. coding data into concepts, subcategories and categories) alongside data collection while conducting field research in Afghanistan to ensure that all categories were accurately defined and sufficiently saturated. Thus, sampling was theoretical rather than statistical, which means the researcher is able to focus on densifying categories instead of reaching a specific number of individuals. Because an impact assessment can generate hundreds of pages of data, rigorous data analysis procedures are critical to organise and make sense of the data.

Second, managers at all levels should pay close attention to socio-cultural phenomena as BoP ventures reach into new, diverse cultures. For instance, Afghanistan is a tribal society. As previously discussed, village elders play a leading role in making decisions and resolving conflict within and between villages and tribes. Village elders typically fulfill these roles in Afghanistan through participation on a shura (e.g. council or committee). Recognising this socio-cultural phenomenon played a critical role regarding social impact of the Tangi Saidan health clinic. If the MSDEV executive team

had not recognised the role of the village elders, the health clinic would have had far less support from the most influential leaders in the surrounding villages. Further, MSDEV acknowledged the importance of including representation from all tribes on the health shura. Consequently, because MSDEV involved village elders from all ethnic groups served by the health clinic, it forced the leaders of different tribes to work together to solve health issues facing their communities. If the organisation would have failed to establish a health shura with village elders or was not able to garner participation from the various tribes, social impact upon interethnic relationships would have been much more limited.

Another example regarding the importance of understanding socio-cultural phenomena pertains to the social impact the health clinic has had upon women. For instance, whereas men have been able to meet publicly in mosques, the health clinic is the only public meeting place for women in the villages. Now that women from different tribes have been able to meet and build relationships at the clinic, this interaction has engendered various social phenomena such as interethnic God sisters, invitations to ceremonies and celebrations of different tribes and interethnic marriages. Further, due to the close proximity of the health clinic, perceived safety of the clinic, familiarity with the clinic and staff, and trust the MSDEV staff has built with community members over time, women have gained relatively greater independence in the Tangi Saidan region compared to other areas of Afghanistan. Therefore, the health clinic has had a significant positive impact upon interethnic relationships in the Tangi Saidan region now that women have a common location where they can meet publicly in the villages independent of Maharam.

Given the socio-cultural phenomena (e.g. health shura, role of women) that were crucial in positively impacting interethnic relationships, managers need to realise that the initial startup and long-term success of a BoP venture could heavily depend upon phenomena that may or may not be obvious to the organisation. For example, MSDEV was aware of the role of village elders regarding decision making and conflict resolution, and the executive team planned accordingly. On the other hand, the organisation was not fully aware of the important role women were playing regarding interethnic relationships. Although the organisation partially recognised this socio-cultural phenomenon, it fortunately resulted in positive social impact. However, this may not always be the case because unknown phenomena can also negatively impact venture success. Therefore, the research study highlights the importance of

comprehensively understanding socio-cultural phenomena regarding the impact of BoP ventures upon poverty alleviation.

Third, the research study results reveal how impact assessment can improve understanding of the target market. MSDEV has known that one of the main target markets it serves is women of child birthing age. Although the organisation has general knowledge of this target market, the study generated deeper understanding of the target regarding economic and social impacts such as breastfeeding, birth control and spacing, antenatal care, birth and delivery, family size and family dynamics. For instance, the research study developed a greater understanding of how breastfeeding babies may save families thousands of Afghanis (Afs) per year. As a result, the organisation can consider focusing greater efforts in this area. Further, the research study revealed that women's perceptions of contraceptives have changed, which has significantly impacted family size and family dynamics. Thus, the research study highlights that impact assessment can help managers deepen their knowledge of the beliefs, values and aspirations of the target market, understand how the target market is changing and determine how to improve impact of the BoP venture upon the target market.

Innovating or developing the business model is the final business, or professional, implication from the research study that may affect organisations pursuing assessment of BoP ventures. This business implication relates to improving impact of BoP ventures. As explained above, it is important to first comprehensively understand impact of the BoP venture such as socio-cultural phenomena or the target market. Once an organisation has developed a comprehensive understanding of economic and social impact, managers are in a position to reassess the business model in order to improve impact. For example, general hygienic practises were identified as an area for potentially improving impact. While health education provided by the clinic staff includes general hygiene, the teaching is informally conducted and more than half of all clinic visits relate to direct or indirect hygiene-related illnesses. With this knowledge, managers can discuss how to improve the hygiene element of health education and possibly innovate curriculum, delivery or marketing components of the overall business model. Resulting innovations may even have spillover effects regarding other elements of health education.

The final business implication is the important role that impact assessment plays regarding communication with stakeholders such as staff, partners and donors. As a result of the research study, the executive team has had many internal discussions among staff and external conversations with partners and donors. For instance, although

some stakeholders had an intuitive sense of the impact the health clinic had on interethnic relationships, no empirical assessment had previously been conducted. As a result, many stakeholders were surprised to see empirical evidence demonstrating the extent to which the health clinic has impacted interethnic relationships. Stakeholders were even more surprised to learn how and why the clinic has had the impact because some of the positive impact upon interethnic relationships was indirect and unanticipated. In particular, stakeholders were generally unaware of the critical role women have played concerning the warming of relationships in the Tangi Saidan region or how family dynamics have changed as a result of the health education provided by the health clinic.

In summary, there are several important implications resulting from the research study. First and foremost, the theoretical implications relate to how the research study addresses the gap in the BoP literature. To address the literature gap, the categories on the final theoretical framework (inductive theory) were compared against the BoP Impact Assessment Framework, and this comparison revealed that the empirical results (inductive theory) were generalisable against the existing theory. In addition, academic understanding of private sector developmental interventions relates to the various content contributions made by the empirical research study, which include BoP venture impact on the poor, BoP research in Afghanistan and BoP research in the health sector. However, there were several limitations regarding the research study such as limited generalisability of the research study and the fact that the research study tests only the Strategic Analysis element of the BoP Impact Assessment Framework.

Consequently, there are opportunities for future research such as testing the entire BoP Impact Assessment Framework (e.g. including both the Strategic Analysis and Performance Analysis), testing the framework in other contexts (e.g. regional, national, socio-cultural, sector) and developing new frameworks to assess BoP ventures. Finally, there are several business implications regarding professional practice in private sector developmental interventions in the BoP market resulting from the study. These include assessment best practices, socio-cultural considerations, understanding the target market, innovating or developing the business model and communicating with stakeholders such as staff, partners and donors. The business implications are relevant for organisations that are planning to pursue (or are currently pursuing) assessment of BoP ventures because they can help managers not only improve effectiveness regarding undertaking the assessment, but also understand the target market better and ultimately determine how to innovate the business model to improve impact.

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